

THE **CANADIAN HOSPITAL**

**OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL**

MARCH, 1951

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8 less Operators needed*

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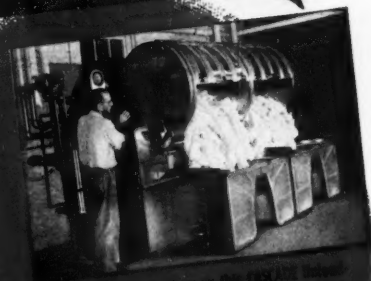
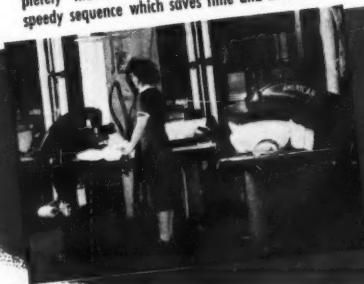
SAVED COST—Fewer operators needed . . . reduction in work hours per week . . . faster return of linens to service . . . mean "a large, definite savings" in laundering costs, reports the management of St. John's Hospital.

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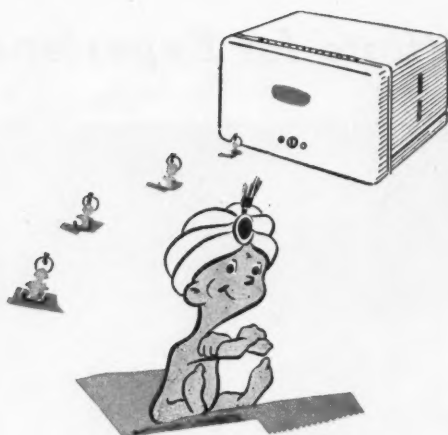
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Contents

Volume 28	MARCH, 1951	No. 3
Obiter Dicta	25	
We Make People Happy	28	
<i>Rev. H. L. Bertrand, S.J.</i>		
Devoirs et Responsabilités d'un Administrateur d'Hôpital	31	
<i>R. Fraser Armstrong</i>		
Second Ontario Institute for Hospital Adminis- trators	32	
Dedicated to Serve Crippled Children (Shriners' Hospital, Winnipeg)	33	
Red Cross Society	36	
<i>W. S. Stanbury, M.D.</i>		
Fire Guts St. Rita's Hospital, Sydney, N.S.	37	
Defence Health Planning at the Federal Level	38	
The Lengthening Life Span	39	
<i>A. H. Sellers, M.D.</i>		
Frederick William Routley, M.D. (Obituary)	41	
Career Night	43	
A Visit to a New Hospital Kitchen	44	
<i>Sister Frances Loyola, C.S.M.</i>		
Taking Stock	46	
St. Mary's Hospital, Trochu, Alberta	47	
Notes About People	48	
Notes on Federal Grants	50	
Provincial Notes	54	
With the Auxiliaries	56	
New Institute of Radiotherapy	66	
Extension Course for Medical Record Librarians....	68	
Coming Conventions	80	

(For Subscription Rates See Page 80)



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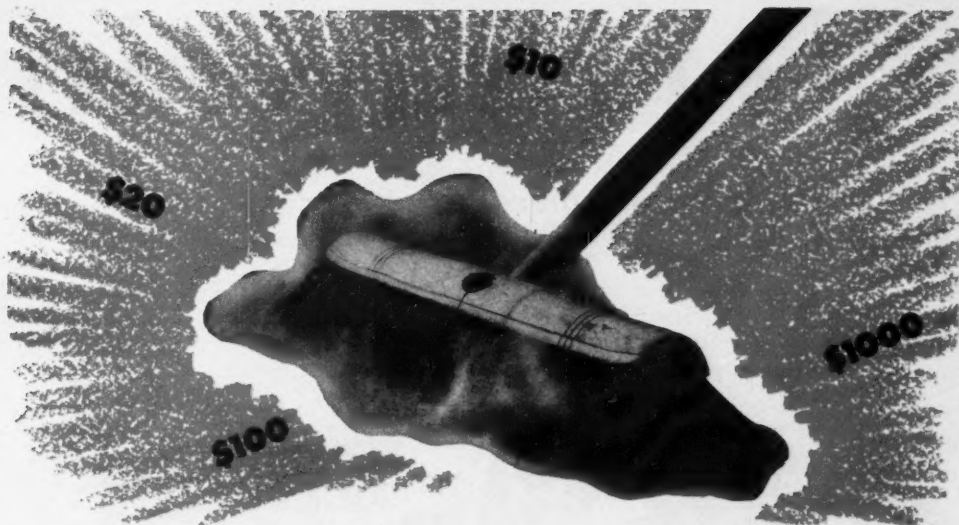
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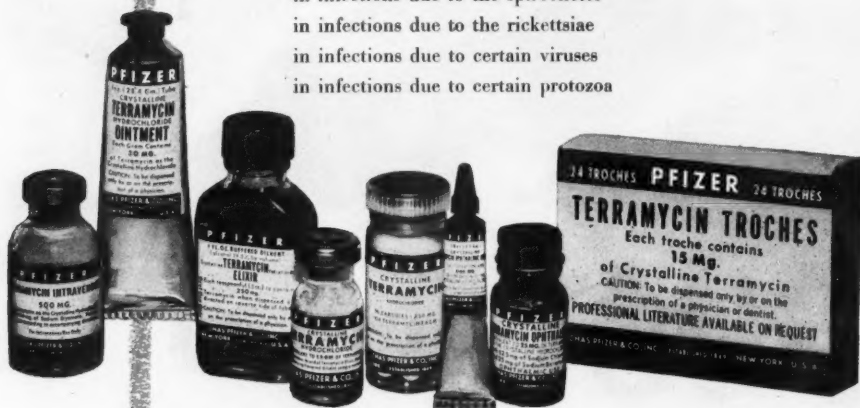
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Dihydrostreptomycin (as the sulphate).....1.0 Gm.

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By virtue of two recent improvements, effected at no increase in price, Crescent Blades are now finer than ever:

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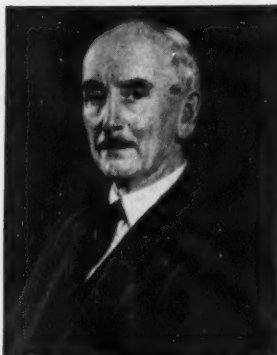
SURGICAL BLADES AND HANDLES

Across the Desk

By C.A.E.

Starts Another Globe-Girdling Journey

The man who has done most to make his Company's products famous in 61 countries throughout the world, Mr. T. L. Moffat, Sr., Chairman of the Board at Moffats Limited, Weston, Ontario, left Toronto in January on another world-wide tour.



Now in his 88th year, the current globe-trotting trip of this foreign trade specialist is no more spectacular than some of the exploits he performed in the early years of the century. On one occasion he cycled from Toronto to Halifax and back—and came home with a book full of orders. Another early

example of his astute salesmanship occurred when he took a carload of ranges to the Canadian National Exhibition, sold the entire lot to customers in the Toronto area, collected payment and delivered the stoves by dray.

* * * *

Recent Changes in Ingram & Bell Sales Representation

Mr. Albert Steen who has represented Ingram & Bell Limited in Southern Saskatchewan for the past year and a half has been transferred to a central Ontario territory succeeding Mr. George Day who is now filling an inside position at the Toronto Head Office. Mr. R. B. Hughes, B.Sc., has succeeded Mr. Steen in Southern Saskatchewan.

* * * *

**C. E. Nettleton is
Fisher & Burpe
Ontario Sales Manager**

Fisher & Burpe Limited announce the appointment of C. E. Nettleton as Manager for the Province of Ontario Sales staff. Mr. Nettleton, who has represented Fisher & Burpe Limited in Ontario for the past five years, will be located at the new Toronto Branch recently opened at 81 Grenville Street.



(Continued on page 16)

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MARCH, 1951

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Clay-Adams

Caudal and Spinal Analgesia Technics Improved by Animal-Tested Polyethylene Tubing

By J. HALPERIN, M.D., Brooklyn, New York

We have been using conduction analgesia in obstetrics since 1943, and our experience in more than 18,000 cases has been very satisfactory. The percentage of partial or total failures has been insignificant. The anaesthetic agent used is Metycaine 1½%. Up to 1950, we employed the needle technic, leaving the needle *in situ* during labor, until the patient was ready for delivery. In Cesarean Sections, the needle was left in the subarachnoid space throughout the operation.

There are, however, a few drawbacks to leaving the needle *in situ* throughout the analgesia period. These drawbacks were overcome by inserting a Polyethylene Catheter through the spinal needle, and then removing the needle, leaving only the catheter in the canal.

In caudal analgesia the catheter is least likely ever to penetrate a low-lying dura and cause an inadvertent spinal instead of an epidural analgesia. After the catheter is inserted and held in



place with adhesive plaster, there is no chance of its coming out through the movements of the patient. There is no danger of a needle breaking during the turning of the patient. The patient can be turned easily from side to side and she may lie comfortably on her back, a position in which one hesitates to place the patient while a needle lies in the caudal canal. If it is desired to continue the analgesia during the delivery, the patient may be transported with perfect safety, without risk of dislodging the catheter.

You may be interested...

- The use, at Bellevue Hospital, of the Ayre wooden spatula for cytological diagnosis of early carcinoma of the cervix, is favorably reported on in *S, G & O*, Dec., 1950, pp. 728, ff.
- Various-sized couplers for attaching polyethylene tubing to Luer-Lock syringes are available from Clay-Adams.
- Two motion pictures may be rented at a nominal fee from Clay-Adams: "Precancer Diagnosis of the Cervix by Cytology," by Dr. J. E. Ayre; and "Obstetrical Maneuvers on the Ayers Manikin," by Dr. H. E. Ayers and Dr. J. Mussio.

Advantages in Fractional Analgesia

Fractional spinal analgesia with the catheter method also offers distinct advantages. A special table mattress is not necessary, as is the case with the needle technic. Once the catheter is in the subarachnoid space and fixed with adhesive plaster, the patient may lie on her back with no danger of dislodgment.

In our work, we chose Polyethylene tubing, which was animal-tested, in appropriate size to go through a 17-gauge needle. We buy the catheter tubing in rolls of 100-foot lengths and cut them into 36- to 40-inch lengths for caudal or fractional spinal use. The length is a matter of choice and convenience. We have not noticed any spinal canal, caudal canal, or other tissue reaction to animal-tested Polyethylene tubing.

Newsletter

FOR THE MEDICAL
AND BIOLOGICAL
SCIENCES

Reproducible Blood Counts Require Accurate Mixing



Accurate, reproducible blood counts are possible only if the blood sample and diluent are homogeneously mixed in the blood pipette. YANKEE Pipette Shakers do this in 30 seconds: far less time and far more accurately than by hand-shaking.

Carefully engineered to give consistently uniform blood counts, YANKEE Pipette Shakers gently rock blood pipettes through a controlled

¼-inch arc in the vertical plane. Horizontal motion is practically eliminated. The rocking arm is motor activated, not vibrated, at a rate of 1550 lateral oscillations per minute.

If the blood-counting chamber is charged immediately after shaking, reproducible blood counts well within the normal margin of error are consistently obtained. The soft circular motion of the pipette beads does not hemolyze the blood cells.

YANKEE Pipette Shakers are available with interchangeable heads to hold two or six pipettes. An adjustable timer automatically cuts off the motor at the end of a 30- to 60-second shaking period. Ruggedly built for long service, YANKEE Pipette Shakers occupy only 5 x 5 x 3½ inches of table space. Rubber suction feet prevent creeping even on the smoothest surface.

Pertinent Questions on R. I. germicide

Visitors to our booth at the recent meetings of the American College of Surgeons, American Society of Clinical Pathologists, and American Public Health Association posed questions about our new Rust Inhibiting germicide. We feel that many of their questions will interest our readers.

Question: Is R. I. germicide a sporicide?

Answer: No. It is a cold germicide with a high germicidal efficiency against many types of pathogenic organisms, but not against spores. If complete sterilization is necessary, we recommend steam sterilization and subsequent storage in R. I. germicide to maintain sterility.

Question: How long can instruments be left in R. I. germicide without dulling the cutting edge?

Answer: Indefinitely. Our own tests reveal that a scalpel left in R. I. germicide for six months shows no pitting or loss of cutting edge in contrast to ordinary germicides.

Question: Must the rust inhibitor be renewed?

Answer: No. R. I. germicide is *permanently* rust-inhibiting. Its germicidal and rust-inhibit-

ing properties remain unchanged until altered by contamination or overdilution.

Question: Can R. I. germicide be used in hard-water areas?

Answer: Yes. Each 10 ml. ampule of R. I. germicide is diluted with ordinary tap water, either hard or soft, to make one quart (or liter) of working solution.

Question: How long must instruments be left in the solution for proper disinfection?

Answer: We recommend that instruments and appliances be left in R. I. germicide for at least 5 minutes before reusing.

SPECIAL LITERATURE AVAILABLE

Detailed descriptions on the following may be obtained from Clay-Adams on request by number:

Caudal and Spinal Analgesia Technics	Form 504
R. I. germicide	Form 503
Polyethylene Tubing and Accessories	Form 447B
YANKEE Pipette Shakers	Form 496A

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Blakeslee Dish Washers

(Continued on page 20)

The CANADIAN HOSPITAL

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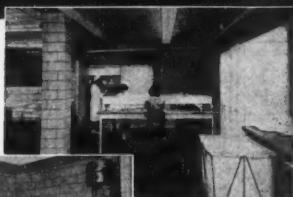


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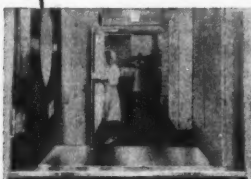
CLEAN WORK ROOM



CLEAN-UP SECTION



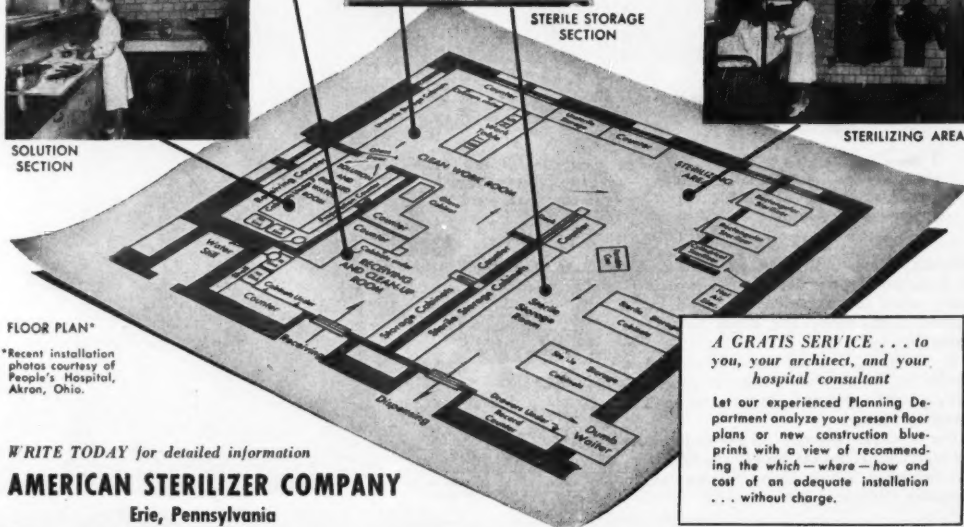
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FLOOR PLAN*

*Recent installation photos courtesy of People's Hospital, Akron, Ohio.

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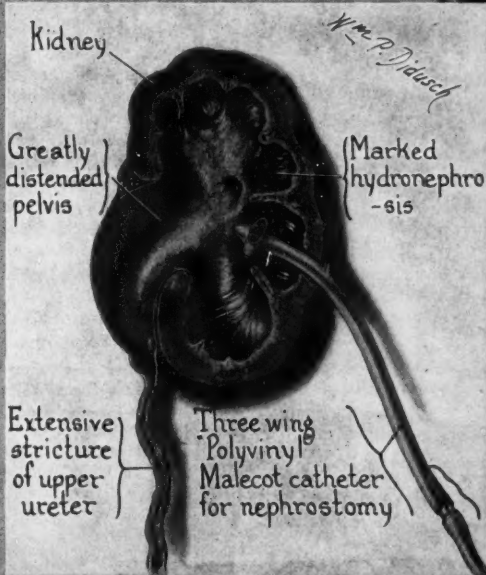
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The illustration to the right shows a Ritter Polyvinyl three wing Malecot catheter placed in the renal pelvis after nephrostomy. It is possible to maintain temporary adequate drainage because Polyvinyl catheters do not plug by the crystallization of urinary salts.



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Across the Desk

(Concluded from page 16)

At the same meeting J. William Stuart, director of the company's Industrial Relations Department, was elected to the Board of Directors.

Mr. McKeen began his career with Pfizer in 1926 as a \$40-a week control chemist shortly after his graduation as a chemical engineer from Brooklyn Polytechnic Institute. Since Mr. McKeen assumed the presidency in 1949, the Pfizer Company, a bulk manufacturer for many years, has made one of the biggest steps in its long history, producing and marketing the newest earth-mold "wonder drug", terramycin, under its own label.

* * * *

Becton, Dickinson Executive Dies

Maxwell Wilbur Becton, Chairman of the Board of Becton, Dickinson and Company, Inc., passed away at his home in Rutherford, N.J., at the age of 82.

Born in Kingston, North Carolina, Mr. Becton moved to Boston in 1893 where he formed a partnership of Randall and Becton as selling agents for clinical thermometers, hypodermic needles and other medical specialties. While on a western trip he met the late Colonel Fairleigh S. Dickinson. Discovering that they were born fifty miles apart in North Carolina, a friendship ensued which strengthened over the next few years and resulted in their buying out Randall in 1897.

They then formed a partnership of Becton, Dickinson and Company, manufacturers of surgical specialties with a small plant in New York City.

In 1906 they moved their business to East Rutherford, where it is now located, and incorporated the concern. Colonel Dickinson became President and Mr. Becton became Secretary and Treasurer.

* * * *

New Thermoplex Server for Hospitals

Coffee and other beverages are kept at serving temperature for up to two hours in a new double-walled beverage server designed for both table service and room

service. It is easily cleaned, non-staining and sanitary, unaffected by soaps, detergents and food acids.

A specially designed pouring lip eliminates dripping. The double-walled insulation keeps the outside and handle completely cool to the touch at all times. Available in various attractive colours, it can be obtained



in quantity with the name of the hospital on its side. Prices and descriptive folder from Thermos Bottle Co. Limited, 1239 Queen Street West, Toronto.

The New CUTTER Saftifilter*

offers Added Safety... Constant Flow...
in Blood and Plasma Infusion

- 1 Pointed tip contains primary filter - a coarse strainer. Pointed tip inserts directly into flask (no stopper needed).
- 2 All-plastic barrel... eliminates rubber ends and danger of breakage.
- 3 2nd filter is the coarse outer nylon mesh. Nylon monofilament prevents filtering of...
- 4 Fine inner nylon mesh for third and final filtration before infusion. Nylon is non-absorbent, thus eliminating swelling of strands and blockage.
- 5 Internal plastic brace which holds nylon filter's rigid during use.

Saftifilter, a new development in blood and plasma infusion, is Cutter's exclusive new all-plastic and nylon filter unit.

Saftifilter, with its triple stage filtering, removes clots and fibrin yet permits a constant flow of blood or plasma.

Cutter's completely new all-plastic and nylon Infusion Sets, with SAFTIFILTER, offer these advantages:

Added Safety—blood or plasma passes through 3 separate filters—complete removal of clots and fibrin.

Expendable—saves space, time and labor costs.

Constant Flow—coarse, medium and fine filters minimize possibility of clogging.

Positive Pressure—sets are designed so positive pressure can be used.

Breakage Resistant—all-plastic and nylon construction.

Ready for immediate use, these sets are sterile, pyrogen-free, easy-to-use, and provide added safety.

Plastic Needle Adapter—ready for insertion in needle. Transparency gives visual evidence of entry into the vein. Softer than metal, results in tighter, more secure fit.

The background of this page is an enlargement showing the weave of the fine inner Nylon mesh filter.

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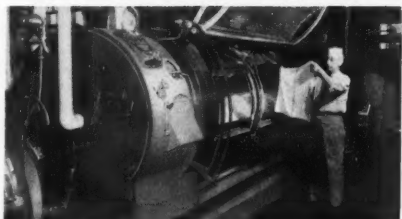
Cutter Laboratories International
Calgary Branch
Union Building, Calgary, Alberta

Earl H. Maynard
17-21 Basin Street
Toronto, Ontario

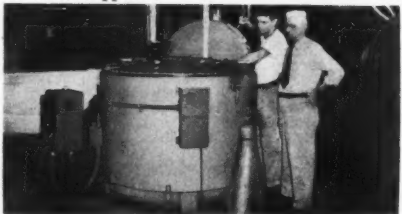


THE SAME-SIZE LAUNDRY
now can do **31%** MORE LINEN

City Hospital of Akron Gains Important Laundry Economies by Modernizing with **HOFFMAN** Equipment



Unique washing principle of the Hoffman "Shell-less" washers processes loads faster—saves space, water, steam and supplies.



The Hoffman 50-inch unloading extractor saves time and cost of handling wet and extracted loads.

Better laundry operation need not mean junking all existing equipment, and sizable new investment. Take the case of the private, non-profit City Hospital of Akron.

A few years back, it decided that laundry efficiency could be improved with larger washers. Studies made by a Hoffman Laundry Engineer suggested the installation of two "Shell-less" washers (for increased capacity and future needs) and of a 50-inch unloading extractor to match their output. Also, recommendation was made that two 36 x 30 "Ucon" tumblers be added for economy in handling small lots. Except for a revised floor arrangement, balance of the equipment was machines already in use.

Without any increase in physical size, capacity of the laundry has been increased 31%. Operation of "Shell-less washers has meant big savings in water, fuel, supplies and linen. With the unloading extractor, washing and handling time and labor have been substantially reduced.

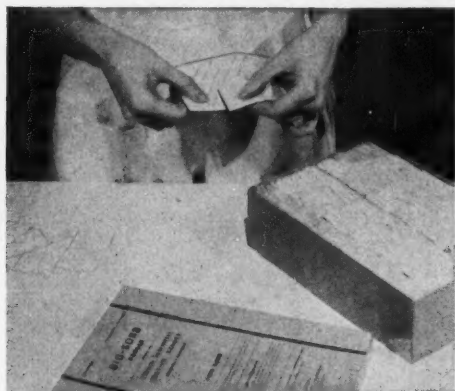
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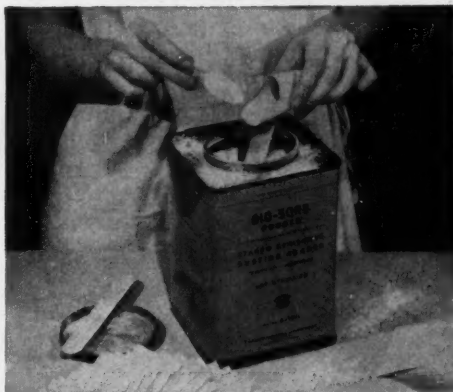
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NEW TIME-SAVING BIO-SORB PACKAGE



THE NEW WAY: All ready for the Autoclave — packets contain enough Bio-Sorb Powder to lubricate adequately the hands of surgeon or nurse.



THIS WORK IS ELIMINATED: The labor cost is saved — hand-filling of envelopes for sterilization is ended by the new Bio-Sorb packet put-up.

Glove Powder Adhesions Eliminated With New Bio-Sorb Starch Powder

Postoperative adhesions caused by glove powder have long been a serious concern of surgeons and operating room assistants. All published studies agree that talc as a glove lubricant is unsafe.

As a replacement for talc, a wholly safe and efficient dusting powder is now available. This new powder, called Bio-Sorb, is a mixture of amylose and amylopectin, derived from corn starch, which has been treated by special physical and chemical means to prevent gelatinization when the product is autoclaved. It is treated physically and chemically to assure good lubrication after sterilization.

Talc consists chiefly of magnesium silicate. It

causes granulomatous reactions in tissue, resulting in intra-abdominal adhesions, persistent sinus formation, or nodules in the wound.

Implantation of glove powder may occur from unwashed gloves, perforations in gloves, spill on to sponges, instruments and suture material, and by the air-borne route.

Bio-Sorb is compatible with body tissues and is rapidly absorbed. It does not injure rubber gloves. It fits regular O.R. technics.

Bio-Sorb has been used over three years in several hundred hospitals. Complete literature mailed on request.



BIO-SORB POWDER

Brand of Starch Derivative Dusting Powder

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Above, right: Surgeons' Scrub-up Sink of Crane Duraclay. Left: Crane Stewardess Sink (less cabinet) of porcelain enameled cast iron.

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You can count on Crane Duraclay fixtures to withstand years of constant usage and retain their gleaming surfaces unmarred by cracks or crazing.

Easy to clean, too — Duraclay sparkles like new after only a light wiping with a damp cloth.

When planning a new plumbing installation or modernizing present facilities — ask your Crane Branch, wholesaler or plumbing contractor for full information on the Crane hospital line. It is a line which includes a complete selection of Duraclay fixtures and *all* the specialized plumbing equipment that hospital service demands.

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L. O. Bradley, M.D., Editor

Toronto, March, 1951

Vol. 28



No. 3

Obiter Dicta

C.H.C. Biennial Meeting —

A Message from the President

THE eleventh biennial meeting of the Canadian Hospital Council will be held at the Chateau Laurier, Ottawa, on May 28, 29 and 30. Official delegates of active and associate members will assemble to debate issues and make decisions of importance to every hospital in Canada.

The meeting is an occasion when leaders in the health field, voluntary and governmental, gather to present, compare and discuss their views. It affords the opportunity to exchange information as well as to make decisions and recommendations that cannot but have a profound influence on the future of hospital care.

Lest there be any misunderstanding, I would like to make it clear that all those interested in hospital work are invited to attend. Although balloting is restricted to active member delegates or their alternates, the sessions will follow a conference pattern, and full participation in discussions by all present will be encouraged.

Those hospitals which will not have personal representatives in attendance are reminded that they will have delegates representing them. Any questions of national significance which they wish discussed should be referred to these delegates through the proper officers of their regional associations or conference.

The program is being prepared and arrangements are being made for a full complement of delegates. Your officers are looking forward to gathering with their many associates from all parts of Canada, to give and to receive advice and counsel in the interests of good hospital service.—R. Fraser Armstrong.

Assemblée Biennale du C.H.C. —

Un Message du Président

L'A onzième assemblée biennale du "Canadian Hospital Council" aura lieu au Château Laurier, Ottawa, les 28, 29 et 30 mai. Les délégués officiels des membres actifs et adjoints se réuniront pour examiner des questions et prendre des décisions importantes pour chaque hôpital du Canada.

L'assemblée fournit aux chefs de file dans le domaine sanitaire, tant bénévoles qu'officiels, l'occasion de présenter, de comparer, et de débattre leurs opinions. Elle permet d'échanger des renseignements, de prendre des décisions et de formuler des recommandations qui ne peuvent manquer d'exercer une profonde influence sur l'avenir des fonctions que doivent remplir les hôpitaux.

Afin de ne laisser subsister aucun malentendu, je tiens à préciser que cette invitation s'applique à tous ceux qui s'intéressent au fonctionnement d'un hôpital. Bien que les délégués des membres actifs ou leurs substituts soient seuls admis à voter, le mode de délibération sera celui d'un congrès, et tous ceux présents seront encouragés à participer activement aux débats.

Aux hôpitaux qui n'auront pas envoyé leurs représentants à l'assemblée, je rappelle qu'ils seront représentés par des délégués. Ces hôpitaux sont priés de soumettre à leurs délégués, par la voie normale de leur association régionale, toutes questions de portée nationale qu'ils voudraient faire examiner.

Le programme est en voie de préparation; toutes dispositions seront prises pour accueillir le plus grand nombre de délégués possible. Nous escomptons le plaisir de nous retrouver avec nos nombreux amis de toutes les

parties du Canada, afin de donner et de recevoir des conseils tendant à rendre toujours plus efficace les services des hôpitaux.—*R. Fraser Armstrong.*



National Conference on Rehabilitation

THE bright light that sent the ground-hog scurrying back to his burrow on February 2nd was the blazing new ray of hope for every disabled or handicapped Canadian, of every age. This was the glow emanating from the First National Conference on Rehabilitation that was held in Toronto on February 1, 2 and 3 of 1951.

This memorable meeting was convened jointly by the Ministers of Labour, National Health and Welfare, and Veterans Affairs, and brought together well over 100 persons from all parts of the country, representing every walk of life. The joint sponsorship and the broad choice of delegates is symbolic of the team-work that is the essence of the rehabilitative process.

The meeting fell naturally into two branches, medical services and vocational services. We, in the health field, are prone to consider that rehabilitation is a medical problem only. Prompt and continuing medical care is, indeed, one of the important factors, but there are several other requirements that are equally important. These are vocational counselling, training or retraining, careful placement in employment, and follow-up.

During the meeting there were evidences of divisional thinking and of special interests at certain points but, as the whole charter developed, it was fine to note

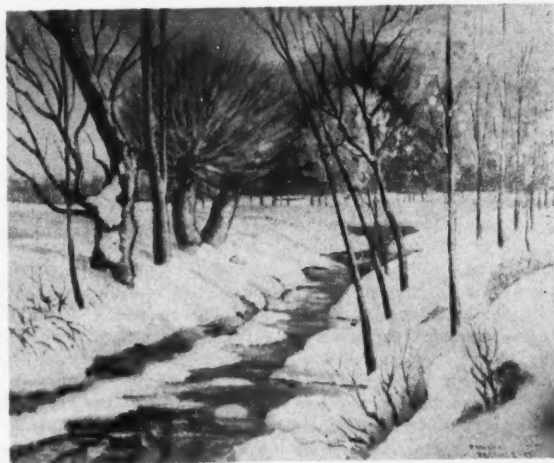
medical people, labour representatives, administrators (both governmental and non-governmental), employers, *et al*, grasp the concept of the whole person and the complete process required for each individual to achieve his best estate in the neighbourhood. This can be attained only by a most extensive integration of services and by the unselfish devotion to duty of doctors, teachers, social service workers, vocational officers, other members of the health team, vocational training staff, placement officers, family, friends, and employers.

An excellent list of resolutions was prepared, carried unanimously, and directed to the Federal Government for action. A full-time secretariate with adequate staff was recommended, as well as a national advisory committee or council to give guidance and direction to the program that can now be developed.

One disconcerting note was the calm acceptance of the shortage of specialist personnel in all categories. True, recommendations to provide training bursaries were set down. This is not enough. New and enlarged educational training facilities for staff are a prime necessity if rehabilitation services in Canada are to live up to the spirit and hope of this meeting.

Hospitals will play a very significant role in this new drama. "Rehab" begins just as soon as possible after admission. Departments of Physical Medicine are being renamed Physical Medicine and Rehabilitation. It is an attitude that must pervade all medical and hospital staff activities. Nor is it limited to our acute hospitals only; it is even more important in the convalescent, especially the long-term, hospitals. The salvage cannot always be 100 per cent but every degree gained helps the community and the patient.

The first half of this century has been distinguished



*The Spring comes slowly up this way,
Slowly, slowly! A little nearer every day.*

—*K. T. Hinkson.*

by great advances in the preventive and curative phases of medicine. We have allowed five years to slip by since the wartime demonstration of the value of sound rehabilitation services. Man power shortages are upon us again. Let us not lose another five years through inactivity now. Delay means great national extravagance and many, many, thousands of personal tragedies. The second half-century could be a triumph for the rehabilitation phase of medical treatment.



Latest Developments in Civil Defence Health Services

WE are pleased to report that definite responsibility for health matters related to civil defence has been allocated to the Department of National Health and Welfare (see page 38). With the results of the Provincial Health Surveys in hand, the Department is singularly suited to the assigned task. As the first step of assembling the inventory is nearly completed it will be possible to proceed with analysis and planning without delay.

It is to be hoped, now, that sufficient time and care will be taken at the federal level to work out a pattern of health services which may be followed by all the provinces and by individual communities. This is very important for in the event of a serious calamity, either through natural or unnatural causes, one province will be dependent upon other provinces (or states), as will one city or area on its nearby communities in the whole supporting region. There should be no cries of central domination or regimentation when integration and co-operation between areas is so necessary and so vital.

It is important too that civil defence health services be developed in relation to, and, as part of, existing health and hospital facilities. Any preparedness program is a "waiting" program—waiting for something to happen—in this case, waiting for something to hit. Great enthusiasm and high morale can be worked up for a few years, but it will be hard to keep up, if the organization waits, and waits, and waits. If civil defence developments are based on sound peacetime extensions of facilities and services, it will be easier to keep morale high and our powder dry.

In order to retain interest and to train an increasing number of administrators or directors, it would seem advisable that tenure of office in all senior positions in the civil defence health services, at the federal, provincial, and local levels, be short—not longer than a year. This will provide safety in numbers (and in dispersement) and will recognize the human factor, that executives like to progress. The first administrators into the field should keep this in mind.

The adaptation of hospital people to this increased community responsibility will not be too difficult. Hospitals by their very nature accept the unexpected as a steady diet. Unfortunately, the task falls on institutions that are now going along on little better than a minimum level of trained personnel. More training facilities are

badly needed if this preparedness is to mean much and, in addition, a larger number of volunteers must be prepared to accept all types of emergency health work. This extension of training may well begin at once for it takes time. This is one aspect of the program that cannot afford to wait.



National Hospital Day — May 12th

THIS special opportunity to tell the story of the community hospital is being more widely appreciated in Canada and is having a very positive effect on hospital-community relations. With increasing competition for manpower, and with the almost inevitable certainty that there will be additional increases in hospital charges, it is more important than ever before that each potential patient, that is, every citizen, understand the community hospital.

There are as many ways and means of celebrating National Hospital Day as there are hospitals in this country. One suggestion is set down in the article on "A Hospital Career Night" on page 43. It is only a skeleton outline to which each administration can add its own ideas. The program will be different in each community, but the outcome will be the same—more good recruits as a result of a public relations effort directed toward a very important group of our population.

Hospitals and other health agencies want the best young men and women of the community. And why not! It means better care for our people, so let's make no bones about it. Let's go get 'em!



Why Our February Issue Was Late

THERE are several minor reasons and one special reason. Prime A Influenza (sounds like a rib roast) laid low our journal staff at a crucial point. Our publishing house, Fullerton Publishing Co., Ltd., were hampered by the same staff situation and just when they were handling a very large issue.

But there is a particular reason that should be brought to your attention. It is a special and unique service of *The Canadian Hospital*. Our epidemiological department reported that large numbers of hospital people were off duty with Prime A Influenza or some other upper respiratory infection. Our medical statistical division reported that, in most instances, physicians were prescribing total rest. Realizing that the attractive February construction issue would demand the full attention of every hospital person, and that it would be read and read again, it was decided to hold it over until our readers had recovered. This would ensure full enjoyment and would indeed have a tonic effect, enabling their return to duty full of vigour and vitality.

No service is too good for our subscribers.

WE MAKE PEOPLE HAPPY —

WE spend a great deal of our time studying our shortcomings, deficiencies, mistakes, the poor financial status of our institutions, and the many other miseries to which we are subjected in hospital life. This is quite understandable and even laudable. I, too, would like to make constructive criticisms concerning our work. However, I would like to look at the brighter side also, and to emphasize the good work that is being done by hundreds of our institutions in this country, towards the welfare of our Canadian people.

Too Luxurious?

One of the most acute and persistent criticisms I have heard of late with regard to our hospitals is that they are too luxurious. Construction costs have become so high that, if further increased, it will be difficult, if not impossible, to raise money required not only to build but to operate these same institutions. There may be some truth in this statement and, for that reason, I feel that it is worthwhile to develop this point to some extent in order that we may avoid even the slightest justification for criticism. I do not refer to the hospitals of any one province, nor to the majority of hospitals in Canada. I have in mind a very small minority of hospitals scattered all over this country, and further, a sort of general trend in hospital construction presently existing in the Dominion. It seems that there is a latent and yet persistent rivalry among our various institutions which drives them, consciously or not, to build a more lavish wing than that of the latest and most modern hospital of yesterday. I have often heard that comment from government officials

From an address presented at the annual convention of the Associated Hospitals of Alberta, Calgary, October, 1950.

Rev. H. L. Bertrand, S.J.,
President,
Catholic Hospital Council of Canada,
Montreal, P.Q.

and, although I have not always agreed with them in the past, I must say that their remarks deserve unprejudiced consideration.

Hospital administrators, architects, and contractors may ask for more details, enquiring where such hospitals are to be found, and demanding to know what exactly makes them luxurious. It is not always easy to point out the precise reasons why one institution is too extravagant and another not, but as one walks through some of the vast and spacious entrances, which alone may have cost a considerable amount (and I have seen them in nearly all the provinces of Canada), one senses that the pervading atmosphere is that of exorbitance. Directly or indirectly, it is the patient who will have to pay for this luxury and, in most cases, he will not even enjoy it. During his stay, he will probably never have a chance to get to the lobby and, when leaving the institution, he will be so enthralled at the prospect of returning home that his mind will have room only for thoughts of rejoining his family and resuming his regular activities. At times I wonder if there should ever have been any suites in our hospitals. However, I might concede that, in large centres, a few could be tolerated but the trouble is that in some sections of the country even regional hospitals have followed this trend, to the great disadvantage of the taxpayer.

I am definitely opposed to those doctrines of socialism and communism which endeavour to place all classes on the same level. However, with respect to health facilities and care, I feel that there

must be some standardization, since only a small minority can afford these spectacular apartments. One does not go to a hospital to lead a Sybaritic life; one goes there to be cured. Facilities for ensuring high quality of medical care cannot be sacrificed to material comfort. This makes me wonder if we have not erred at times in this particular matter. Perhaps in the past we have attached too much importance to the impeccable cleanliness of our institutions and too little to their scientific improvement. We have scrupulously dusted tables and chairs while being reluctant sometimes to equip fully our laboratories and other professional departments, or even to provide adequate fire protection for our patients. Of first importance are good medicine, good surgery, and good nursing service. If something is to be sacrificed in our hospitals for the sake of economy, it must be what is known, or should be known, as luxury.

Many are of the opinion that we should have very few rooms with baths in our hospitals. The great majority of patients will seldom, if ever, use them; at least they are not worth to the patient the price they cost and that we must ultimately charge him. Some are inclined to think that a toilet for every room can be considered an extravagance. Would not a toilet between two rooms be sufficient? When one realizes the high cost of plumbing today, one cannot but think of the money involved in the installation of such items. But the people want all this! It is possible. Nevertheless, I feel that too often we lift some things into the realm of necessity which are far above our average standard of living.

I can visualize a private room being perfectly equipped with the following: an excellent bed, a wash basin, a toilet between two rooms,

one comfortable chair for seating our patient when he gets up, and the remainder of the furniture as modest as can be; one or two more common and harder chairs for the visitors—so hard that they will stay only a short time in the room. It is possible that the criticism concerning luxury gradually entering into our institutions is well founded. Briefly, we should spend less money on secondary conveniences and more on professional excellence.

Do We Make Money?

The criticism that hospitals make a profit is about as old as the most ancient hospital. If it comes from the people, I think our duty is to produce the official statements that will convince them of the contrary. I know of some administrators who prepare a monthly financial statement for the medical board, and I would not hesitate to recommend this policy which promotes understanding between the staff and the administration. If the criticism comes from government officials, I would not attempt to answer because they should, and in most cases do, know better; it is so evident that hospitals do *not* make money.

Do Our Hospitals Practise Charity?

We must never forget that charity begins at home and that we must first pay our bills and our employees before we can even attempt to give to charity. Justice comes first. May I add that we have, in fact, always given to charity, because we have cared for our public ward patients at a rate paid by governments—a rate much lower than the actual cost.

Should We Have Open Hospitals?

The criticism regarding closed hospitals comes, as a rule, from general practitioners who have been barred from practising their profession in our hospitals. We may have been a little rigid in this regard. In fact, I think we have; but this does not mean that we should open our doors to the first comer because he has a university degree to practise medicine. If we are going to keep up our standards, and, what is even more important, if we are going to elevate them, we must control our surgery and medi-

cine. In order to do this, however, we must by necessity control the admission of our doctors and submit them to certain rules and regulations drawn up by the medical staff and approved by the hospital. This practice has brought out a good deal of criticism on the part of some doctors. Administrators and boards of directors, they claim, are definitely too independent and too jealous of their rights and privileges. "The hospitals belong to the doctors" said a physician at a recent medical convention. This is not true. The hospitals belong to the people, represented by the board of directors in our lay and religious institutions and by governments in our governmental institutions. The relationship between the board of directors and administration on the one side and the medical staff on the other should be one of complete harmony. The former should treat their doctors in the most courteous way because good doctors are an asset to the hospital. The doctors, too, should remember that they owe a great deal to the institution which provides them with such a magnificent workshop.

Do Too Many People Go to Hospital?

Years ago, we used to encourage people to go to hospital. Today, some are of the opinion that we should do the opposite. Is it true that, due to various health and medical plans, people have become hospital-minded and request hospital services for apparently minor

ailments which might have been treated at home? There may be some truth in this statement, but there is much more exaggeration. I do not think that today I would recommend any woman giving birth to a child in a private home. I do not believe that, in this modern era of progress in the medical and hospital field, I would recommend anyone having his tonsils removed in the private office of any doctor, unless it were absolutely necessary. If I should do so, I would feel guilty of not advocating sufficient precaution to avoid serious complications and even fatalities.

What has just been said in the two previous instances could apply to dozens of surgical and medical cases. So much so that after you have considered each case individually you will generally hesitate to blame people for coming too often to the hospital.

How far can one go in recommending private clinics and home treatments? It is rather difficult to say. It is probably a question of practical judgment for each individual case, but there is certainly a danger in insisting too much on treating people in their own homes. The reason for this is rather obvious. Whenever there is a complication, or whenever the disease becomes more serious, it might already be too late to do anything in the hospital.

However, the general practitioner still faces a serious problem. Will he completely disappear in years to come as people continue to flock to hospitals and to entrust themselves more and more to the care of specialists, or will he continue to practise his art in private homes and remain, as he was considered in the past, the foundation of professional medicine? Personally, I think that his departure would be a calamity, but it is difficult to find an adequate solution to his worries.

I would like to divide the general practitioners into two classes—those who live in a city or at least close enough to a hospital to be able to practise therein if they so desire and, secondly, those to whom such an institution is inaccessible. Except in our university hospitals, we should open our doors to this first class. They play an important part in the nation's



Rev. H. L. Bertrand.

health. However, like all others, they should be strictly subjected to the rules and regulations governing the medical staff and the hospitals. This first class of practitioners does not constitute a problem because, if they are competent, they will always be welcome in our institutions. The second class of practitioners (those to whom such an institution is inaccessible) have a serious problem. They have my complete sympathy, and although I myself can offer them no adequate solution, I would eagerly welcome the suggestions of anyone who can.

Brighter Aspect

In the foregoing, I have dealt

★ ★ ★ ★ ★ ★ ★ ★

Un Résumé

D'ordinaire, la majeure partie de nos congrès se passe à discuter les difficultés de tous genres rencontrées dans le domaine hospitalier. Discussion souvent déprimante, alors que les congrès devraient être des stimulants dans la poursuite de notre oeuvre si belle.

Ce matin, nous étudierons d'abord quelques critiques à l'endroit de nos hôpitaux. Nous terminerons sur une note plus optimiste, en démontrant que nos institutions contribuent au bonheur de notre peuple.

Critiques

1. *Nos hôpitaux sont trop luxueux.* Critique acerbe et très répandue, mais que je crois fondée. L'importance, dans un hôpital n'est pas dans la richesse de l'ameublement ou la beauté des murs, mais dans l'assurance qu'il sera donné au patient le meilleur service possible en médecine et en chirurgie. Il existe une trop forte tendance à pourvoir nos institutions de suites luxueuses.

2. *Nos hôpitaux sont riches.* Seule l'ignorance des faits peut excuser une telle assertion.

3. *Nos hôpitaux ne pratiquent plus la charité.* Critique malfaisante et erronée. Quand nous traitons nos malades des salles publiques avec un écart considérable entre les déboursés et les revenus, n'est-ce pas là pratiquer une charité d'autant plus pure qu'elle est méconnue?

4. *Nous devrions avoir des hôpitaux "ouverts"!* Pour les hôpitaux

with old and new criticisms within our field, and I would now like to consider the brighter aspects of our work. These can be summed up in a few words, namely, we make people happy. We are not overlooking our deficiencies in the health field, but we must never forget that the only reason the various governments and boards of directors establish hospitals is to provide better medical care in order to save more lives, improve the health of the people, and hence promote happiness within our nation.

Numerous non-profit health plans have been introduced from coast to coast and I am sure that there was never even a thought of making

universitaires, nous condamnons ce procédé. Pour les hôpitaux non universitaires, je crois que, tout en exerçant un contrôle efficace sur notre médecine et notre chirurgie, il faudrait être moins sévère, surtout à l'égard du médecin praticien. Si ce dernier venait à disparaître, comme la chose est possible si nous continuons à restreindre ses activités, ce serait un grand mal pour la médecine et pour le pays.

5. *Trop de personnes vont à l'hôpital.* Après avoir encouragé, depuis nombre d'années, nos gens à se rendre à l'hôpital dès qu'ils se sentent malades, afin de prévenir un plus grand danger, il serait pour le moins ridicule de leur conseiller le contraire maintenant. Tout de même, nous croyons que les jours d'hospitalisation pourraient être considérablement diminués.

Aspect Plus Reconfortant

De toutes ces critiques, les unes sont totalement fausses, les autres totalement vraies, bien qu'exagérées pour la plupart. Nous sommes portés à croire, après les avoir entendues, qu'il s'accomplit relativement peu de bien dans nos hôpitaux. C'est le contraire qui est vrai: sans eux, des milliers d'enfants ne jouiraient pas de la vie; des milliers et des milliers de grandes personnes disparaîtraient sous le coup d'épidémies non contrôlées.

Bref, malgré toutes nos déficiences, nous réalisons beaucoup de bien et le seul but de notre existence n'est-il pas de faire des heureux?—H.L.B.

money in any one of these plans. We have built better hospitals and encouraged better medical care, never with the intention of material gain for ourselves. However, as I mentioned above, many of our hospitals have been accused of being mercenary. Personally, I think that we owe money to no-one, but if we could reduce the true value of our work to monetary terms, we would have a fortune owing to our institutions. We are very thankful to our various governments for their many contributions in helping us defray building costs. Without their help, I wonder what would happen to us. Today, I am happy to acknowledge publicly the wonderful contribution they have made to the welfare of the citizens of this country. When we receive grants from the governments or subsidies for the poor, we may not owe anything to the governments in terms of dollars and cents, but we do owe them a profound debt of gratitude for helping us so efficaciously in promoting better health, and hence more happiness within the various provinces in the Dominion of Canada. I would like, therefore, to say a hearty "thank you" to our leaders who have understood so well their responsibilities in the health field, municipal, provincial and federal.

There are a multitude of objections pouring in from outside with regard to our high hospital costs. I may say that I sympathize with a great number of our people who find it a heavy burden to pay their hospital bills. Many other Canadians are reluctant to pay their bills on the pretext that they are too high. I would say that to a certain extent, we, ourselves, are responsible for this unjust criticism. We have done too much for our people. We have done so much that our services have not been appreciated. A man who will not hesitate to pay six or eight dollars for a bottle of liquor may object strenuously to paying the same amount for a day of hospital care. He thinks it is too expensive! Every winter there are thousands of people who are ready to pay, and in fact who are paying, up to \$150 for season tickets to hockey games. But they consider an x-ray series
(Concluded on page 88)

Devoirs et Responsabilités d'un Administrateur d'Hôpital

Part I

L'ère que nous vivons est consciente de sa sécurité sociale. L'on attend beaucoup des décisions qui seront prises en ce qui concerne la conduite d'un hôpital et ces décisions auront une influence profonde sur le bien-être et le bonheur futur de notre peuple canadien. Elles doivent apporter ce dont il a besoin: le fonctionnement économique et effectif de l'hôpital; elles pourront, d'autre part, conduire vers des résultats déplorables.

Les décisions gouvernementales n'ont jamais été aussi importantes que de nos jours. Seront-elles déterminées par une émotion ou basées sur une pensée claire? Il est temps de reconnaître et d'admettre les avis des personnes dont les jugements sont tempérés par l'expérience acutelle du gouvernement d'un hôpital.

Des Avis Eclairés Sont Requis

Se trouve-t-il des personnes, autres que les administrateurs d'hôpitaux, mieux préparées à donner des avis éclairés? Je ne crois pas, car environ une personne sur dix de population peut s'attendre d'entrer à l'hôpital chaque année; l'administrateur les rencontre personnellement, les familiarise avec les problèmes économique du service hospitalier et leur fait connaître ce que l'on est en droit d'en attendre.

Nos administrateurs doivent-ils s'associer à la lignée et laisser dominer la situation par des personnes, inexpérimentées ou accepteront-ils le défi et reconnaître qu'une partie importante de leurs devoirs et responsabilités consiste à diriger le

D'après un discours donné le 27 juin, au Seizième Congrès des Hôpitaux Catholiques de la Province de Québec, organisé par le Comité des Hôpitaux du Québec.

R. Fraser Armstrong,
Surintendant,
Kingston General Hospital,
Kingston, Ont.

courant des idées vers des décisions sages et prudentes.

Nouveau Principe en Administration

Les provinces canadiennes ont attaqué directement le problème de l'administration des hôpitaux généraux. Il est trop tôt pour faire des commentaires ou des critiques sur leur nouvelle façon de comprendre l'organisation administrative d'un hôpital. Elles peuvent avoir ou non la solution du problème, mais il vaut mieux réserver son jugement pour le moment. Les observations faites sur une longue durée sont importantes et plus probantes.

Quelle en sera l'influence de cette nouvelle façon d'agir sur la fibre morale et sur l'indépendance de notre peuple? Les privilèges qui en découlent seront-ils exploités, amenant des constructions coûteuses inutiles? Des administrateurs qualifiés continueront-ils d'être attirés



R. Fraser Armstrong.

vers le milieu hospitalier? Les hôpitaux deviendront-ils la machine électorale du politicien amenant comme déplorable résultat: la perte de leur autonomie locale et la nomination de ses administrateurs et de ses directeurs par l'autorité provinciale?

D'autres provinces pourraient considérer cette nouvelle façon de procéder comme une expérience et la comparer avec les possibilités que leur offrent leur ligne de conduite actuelle et celle d'autrefois.

Ancien Principe d'Administration

Depuis plusieurs années, le service hospitalier a été maintenu dans les hôpitaux généraux, grâce à des intérêts perçus sur des revenus venant de sources diverses: le malade, le public, et des personnes charitables qualifiées de philanthropes. En procédant ainsi, le fardeau était partagé; un service de haute valeur accordé au malade; la philanthropie encouragée et l'autonomie locale de l'administration conservée.

Tant d'heureuses conséquences valent la peine qu'on étudie de près, cette façon d'agir, que l'on en reconnaisse les faiblesses et les possibilités de les faire disparaître. Ces faiblesses ne saurient venir du principe; elles viennent d'un mauvaise distribution du coût total. L'idéal serait que le coût soit également réparti entre ceux qui doivent le défrayer. L'hôpital est un service d'utilité publique; en effet, ce sont les provinces et les municipalités qui en bénéficient et elles devraient prendre leur part équitable de ce qu'il coûte, sans oublier les dépenses additionnelles d'un programme éducatif et une forte proportion d'imprévu.

Le coût total, ainsi réparti, laisserait aux malades payants la responsabilité de leur propre hospitalisation et des dépenses encourues pour un service dit de luxe. Les individus, de leur côté pourraient se protéger en prenant partie d'un plan d'assurance hospitalière volontaire.

Principes Démocratiques

Pourquoi les citoyens s'intéressent-ils tant au bien-être de nos hôpitaux? Pourquoi des personnes, éminentes dans la société, veulent-elles appartenir au Bureau de Direction de nos hôpitaux? Parce qu'elles apprécient la liberté de notre mode

Kalkulationen: Hauptzweck ist es
 den Kosten der Produktion zu ermitteln, um
 diese mit dem Verkaufspreis zu vergleichen.
 In der Kalkulation werden die Kosten der
 Produktion in fixe und variable Kosten
 unterteilt. Die fixen Kosten sind die
 Kosten, die unabhängig von der
 Produktionsmenge sind. Die variablen
 Kosten sind die Kosten, die mit der
 Produktionsmenge variieren.

Intensificando os procedimentos de controle interno, a Companhia assegurou a confiabilidade da informação da contabilidade consolidada e do balanço patrimonial, demonstrando a integridade da gestão financeira e a transparência da prestação de contas. Os procedimentos de controle interno e de gerenciamento de riscos foram avaliados e aprovados pelo Conselho de Administração da Companhia, sendo aprovada a declaração de que os procedimentos de controle interno e de gerenciamento de riscos são adequados para assegurar a confiabilidade da informação da contabilidade consolidada.

Tausend Seelen in Seufzern
 der künftigen Abgeschiedenen

The annual General Assembly for hospital administration will be held at Queen's University, Kingston, the week of May 16. This assembly is sponsored by the Ontario Hospital Association, with the cooperation of the Canadian Hospital Council, the American College of Hospital Administrators, and Queen's University. Several committees have been set up and are functioning under the general chairmanship of R. Fraser Ross, M.D., F.R.S.C., superintendent, Kingston General Hospital, and currently president of the Ontario Hospital Council. The Program Committee chairman is S. B. Mallon, M.B.B., M.D., superintendent of the Hamilton General Hospital, and the chairman of the Committee on local arrangements in Kingston is G. W. Peacock, M.D., assistant superintendent (medical), Kingston General Hospital.

[illegible]

Key Words: *depression; coping strategies; self-esteem*

Le dote d'organisations de
travail et de relations sociales
de la part des entreprises
est telle qu'elle conduit les
syndicats à se désolidariser
de la lutte pour l'emploi et
à se consacrer à la défense
des intérêts sociaux et
économiques de leurs
membres.

[illegible]

Les provinces de l'ouest, à moins
précisément chaque un programme au
niveau attendu qu'il est un
niveau de succès pratique admini-
strative. L'ouest est une certaine
manière de la partie de la zone
économique et proportionnelle de se
servir d'un département dans l'inter-
venir ne augmentent de la contri-
bution municipale. Les provinces
surtout physiquement les in-
dicateurs de l'ouest sont d'obtenir
de succès. Elle a peut-être le
solution réelle au problème hospitali-
er de la fin de tout prix.
surtout de la

The International Symposium on Server-Side Computing

Le confiance mutuelle et le travail d'équipe nécessaire à la bonne administration, son assure lorsqu'un Bureau de Direction bien organisé et un administrateur compétent travaillent ensemble et entretiennent de bonnes relations mutuelles.

Pour arriver à ce résultat, nous devons avoir une compréhension nette de la façon dont fonctionne le Bureau de Direction et des principes de fonctionnement de l'administration.

À vrai dire, cette dernière, pour être harmonieuse et aussi parfaite que possible, dépend de la coordination bien faite entre les divers départements de l'hôpital—responsabilité qui incombe au Bureau de Direction.

L'administrateur doit avoir entière juridiction sur tous les départements de l'hôpital, sur leur coordination et sur tout ce qui est propre à maintenir un bon service hospitalier. De plus, c'est son devoir de porter à l'attention du Bureau de Direction, les directives qui s'imposent. Après avoir fourni au Bureau, les renseignements nécessaires, et fait les recommandations jurées utiles, c'est à ce dernier qu'incombe la responsabilité des directives à donner. (4 *avril*).



Shriners' Hospital, Winnipeg, Man.

Dedicated to Serve Crippled Children

CRIPPLED children from many provinces find new health and hope at the beautiful hospital erected for their benefit by the Khartum Temple Shriners of Winnipeg, Man. Here, children ranging

in age from infants to boys and girls of 14 receive the orthopaedic treatment they could not afford otherwise.

The history of this hospital actually begins in 1925, when the

Shriners opened a unit for crippled children in a wing attached to the Children's Hospital, Winnipeg. In 1945, the Khartum Temple began to plan a separate hospital to serve the crippled children of western Canada. Throughout 1946, offers of assistance came from Shriners of Calgary and Regina, and an official campaign for funds was launched. Opened for patients in June, 1949, the new well-equipped hospital can not only accommodate more patients than it could before as a small unit but also provides better care and helps to speed recovery.

The one and a half-storey, 40-bed building is situated on terraced grounds which slope gently to the banks of the Assiniboine River. It has a handsome exterior of red tapestry brick with Tyndall stone trim, while graceful white pillars give an air of Grecian dignity to the entrance.

Directly inside is a circular reception hall, with the shriners colourful crest in the centre of the terrazzo floor. Alcoves in the rotunda contain the decorative shovel which turned the first sod, tools used in laying the cornerstone, the dedication plaque, and the "Gold Book" which records the names of all donors.

Beds, cribs, and bassinets are ar-



With a huff and a puff.



A section of the bright and spacious girls' ward. Walls are painted a soft blue and furniture light pink. The cubicles seen at right are of stainless steel.

ranged in two large wards, situated on the main floor. On the left side of the building, the girls are accommodated, while the boys' ward is on the right. Babies have separate, glassed-in, stainless steel cubicles which are located at the ends of the wards nearest to the nursing station. Bright, cheerful day rooms are provided for the more active children as well as a patio, situated at the rear of the building, which is an attractive place to obtain fresh air and

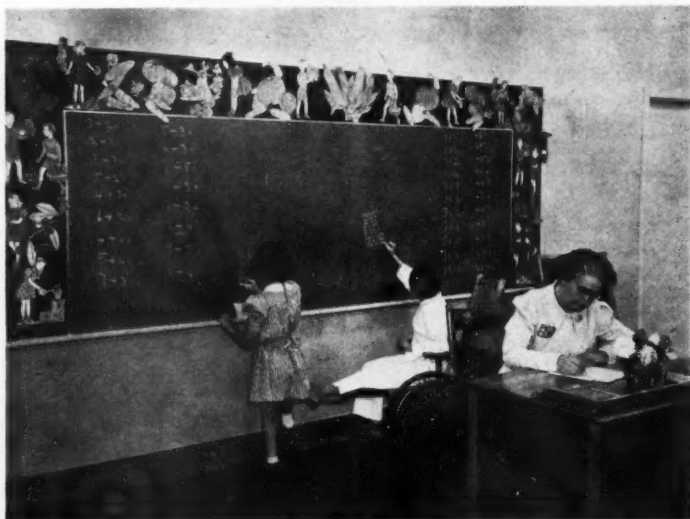
sunshine in warm weather. It can be reached from the hospital by means of a ramp especially built for wheelchair patients. Both wards and patio face the river, thus providing a lovely view for small patients at all times.

Services and Equipment

The two operating rooms are located in the upper storey of the hospital, as well as related facilities such as utility rooms and steriliza-

tion units. The operating rooms have walls built entirely of glass brick and contain modern equipment of stainless steel, multi-beam operating lights, and emergency lighting equipment.

In the basement are the outpatients' department, examination and dressing rooms, x-ray office, and physio- and hydro-therapy rooms. A brace-making unit is located on this floor as well as a large play-room. The latter is often used for enter-



A corner of the school room shows the green chalk board with border of darker green cork board used to display the children's work.

Who wouldn't smile in such pleasant surroundings.



tainments and serves as a meeting place for the ladies' auxiliary.

From the basement, where food coolers and dish-washing rooms are housed, an underground tunnel leads to the nurses' quarters in a former large private home. The kitchens are located in this residence although there are small serveries off the wards on the main floor of the hospital which provide between-meal snacks and refreshments.

Nurses' stations are glass-walled and so situated that they permit observation of every part of the ward. All equipment is of the most modern available for the treatment of crippled children and includes a Hubbard hydro-therapy bath and a treatment pool.

A Child's Wonderland

Originality, artistry, and colour have been combined in the decora-

tions throughout the hospital to produce an atmosphere of lightness and gaiety so stimulating to the well-being of young patients. Story-telling murals brighten many of the rooms. In the boys' ward, letters of the alphabet are featured with each letter depicting an object, from "A" for acorn to "Z" for zebra. From their beds, little girls can see such wondrous sights as Bambi speculat-

(Concluded on page 78)



The gay playroom features colour and amusing murals. The ladies' auxiliary who meet here once a week supply wearing apparel for all children while they are in hospital.

Volunteer aid in peace or war —

Red Cross Society

RED CROSS was born on the battlefield of Solferino* some ninety years ago. Silhouetted against that scene of carnage stands an almost legendary figure—the Swiss banker, Henri Dunant, who was there caring for the wounded and dying. By October, 1863, "The Committee of Five", formed of Genevese citizens with Dunant as secretary and spiritual leader, was instrumental in summoning the first Geneva Conference which was attended by 26 delegates from 17 different nations. From this conference emerged the so-called First Geneva Convention, entitled "Convention for the Amelioration of the Condition of the Wounded in Armies in the Field", which was and still is the foundation on which the Red Cross work of the whole world rests in international law. This solemn international covenant, unlike so many others which have been discarded as "scraps of paper", has been respected by some 63 nations, many of them frequently at total war, during the last century.

In succeeding years, three additional Geneva Conventions have been formulated, the second dealing with maritime warfare, the third establishing humane treatment of prisoners of war and the fourth setting up measures for the protection of enemy civilians in belligerent countries. These four covenants as international law represent, perhaps, the greatest hope and safeguard for our civilization today.

Red Cross Flag in Canada

In Canada, the first Red Cross flag was flown in 1885 by Surgeon-Major George Sterling Ryerson, later Major-General, Canadian Army Services, at the Battle of Batoche

*In Italy. Battle, in 1859, was part of the struggle for the unification of Italy.

W. S. Stanbury, M.D.,
National Commissioner,
The Canadian Red Cross Society,
Toronto, Ont.

in the Northwest Rebellion. To distinguish his primitive ambulance from the army wagons, he devised a flag of white factory cotton upon which he stitched the Geneva Red Cross. Material for the cross consisted of turkey red cotton borrowed from an ammunition column. With the return of peace, General Rye-

"The purpose of the Society shall be: to furnish volunteer aid to the sick and wounded of armies in time of war . . . (and) in time of peace or war to carry on and assist in work for the improvement of health, the prevention of disease, and the mitigation of suffering throughout the world."—from the Charter of the Canadian Red Cross Society, organized 1896, incorporated 1909.

son, 1896, was instrumental in organizing a Canadian branch of the British Red Cross Society, which, in May, 1909, was incorporated by Act of Parliament as an autonomous national Red Cross Society.

In War-time

During two World Wars, the new national society was mindful of its primary purpose: to furnish volunteer aid to the sick and wounded of armies. In World War II, 641 volunteer members of the Canadian Red Cross Corps served in Britain and on the continent, in Canadian Red Cross hostels, as welfare workers in R.C.A.M.C. hospitals, and as ambulance drivers with the British Red Cross Society. Over 2,500,000

pints of blood were collected in Canada for use as dried serum by the armed forces of the allies; countless numbers of hospital supplies and comforts were manufactured by volunteer workers; and nearly sixteen and a half million food parcels were shipped to Europe for distribution through the International Committee of the Red Cross to our prisoners of war and those of our allies.

In Peace

With peace came a realization of the stupendous problem of rehabilitation which faced the world. As a voluntary organization dedicated to "work for the improvement of health, the prevention of disease, and the mitigation of suffering throughout the world", and as a member of the League of Red Cross Societies, the Canadian Red Cross was obligated to do its part in relief work for the millions of refugees, displaced persons, and other destitute civilians throughout Europe and Asia. During the years 1939 to 1950, over \$45,000,000 (including designated funds from other organizations) was spent in the purchase of medical and hospital supplies, food and clothing, as well as tens of thousands of garments, bedding, and hospital supplies manufactured by volunteers of the Women's Work Committee. Nor were our own Canadian veterans forgotten. Eight beautifully-furnished lodges were built adjacent to Department of Veterans Affairs hospitals to provide home-like surroundings, comfort, light meals cooked by volunteer workers, recreation for thousands of veteran patients, and overnight accommodation for their next-of-kin. Within 28 D.V.A. institutions themselves can be seen perhaps the finest project that the Red Cross has undertaken for veterans, an Arts and Crafts program. This, according to a former Deputy Minister of Veterans Affairs, is making a very real contribution toward the rehabilitation of veteran patients as well as providing them with a lifetime hobby and possible means of livelihood as well.

Out of the efforts of the war years emerged one of the most valuable peace-time undertakings of the society—the National Blood Transfusion Service. Blood is collected



Fire Guts St. Rita's Hospital, Sydney, N.S.

Early last month fire gutted the 60-bed St. Rita's Hospital at Sydney, N.S., which is operated by the Sisters of St. Martha. All 57 patients, including infants and cripples, were evacuated safely. Firemen, sisters, and nursing staff of the hospital were assisted by hundreds of volunteers in the rescue work, which was carried out in a cool, orderly manner, within about 10 minutes. Other hospitals in the district opened their doors to the evacuated patients.

Fire was first discovered near the elevator shaft on the third floor and continued to burn, heightened by a high wind in drizzly weather, between the walls of the four-storey, brick building. The top floor was completely destroyed and the remaining floors were ravaged by fire, smoke, and water.

Much equipment was saved, but damages are estimated at around \$500,000. The loss of this hospital leaves the city with only one large general hospital—the City of Sydney Hospital. Just two weeks before the fire, the Sisters of St. Martha had signed a contract for the building of a new 185-bed hospital, to cost approximately \$1,850,000, construction of which will probably be hastened due to the present lack of facilities.

from voluntary donors and processed in Red Cross Laboratories housed in premises provided by provincial governments. Both fresh blood and dried plasma, (with sterile administration sets and pyrogen-free, distilled water for reconstitution of the plasma) are distributed free to hospitals and, through the courtesy of hospitals, administered without charge to patients. Now organized throughout the provinces of British Columbia, Alberta, Manitoba, Nova Scotia, New Brunswick, and Prince Edward Island, as well as in portions of Ontario and Quebec, the service is scheduled to open in Saskatchewan as soon as suitable premises for laboratories can be made available by the provincial

government. In the year, 1950, Canadian men and women freely gave over 190,000 pints of their blood that others might live. The importance of this nation-wide service in national defence has just been recognized by the Honourable Brooke Claxton, who has appointed the Canadian Red Cross Society as the official agency to supply all blood and blood products required by the armed forces and has also requested that the society stockpile plasma for civil defence.

During the period between the two wars, the society concentrated on its nursing and hospital services, pioneering in the field of public health nursing, and establishing outpost hospitals in frontier areas. The

number of these outposts and nursing stations has now grown to over eighty, and as some are taken over by their local communities, others are established in more needy districts. Other nursing projects administered by its provincial divisions are Sickroom Loan Cupboards, supplying some 15,000 patients a year, voluntary instruction in home nursing and the maintenance of an emergency nursing reserve.

The Junior Red Cross

The Junior Red Cross, with the co-operation of the Provincial Departments of Education, is an in-school movement, which teaches the young people of Canada the basic fundamentals of health and seeks to

(Concluded on page 76)

Defence Health Planning at the Federal Level

THE Department of National Health and Welfare has assumed responsibility for advising the Civil Defence Co-ordinator, General F. F. Worthington, on health and welfare matters. In this connection, the department will initiate and co-ordinate civil defence health and welfare plans at federal level.

Certain preparatory steps such as the training of personnel and collecting basic information on the subject have been taken by the department. A co-ordinating committee has been set up consisting of the following members: G. D. W. Cameron, M.D., G. F. Davidson, M.D., H. A. Ansley, M.D., R. B. Curry, and K. C. Charron, M.D. In addition, a health planning group is being established, with personnel working on a full-time and part-time basis. This group will assist in developing a general pattern which may serve as a guide for provinces and municipalities concerned with civil defence health service planning and will be under the supervision of Dr. K. C. Charron.

The national and professional associations and voluntary agencies interested in various aspects of the program will be invited to co-operate and participate in this planning effort. Similarly, various specialized services within the Department of National Health and Welfare and other federal agencies will be fully utilized.

Small working parties will be set up to explore various aspects of civil defence health services such as:

1. Civil defence casualty services (first aid, ambulance, emergency hospitals, et cetera).
2. Sanitation services.
3. Laboratory facilities.
4. Nutritional problems.
5. Industrial medical services.
6. Special health services (such as paediatric, obstetrical, mental hy-

giene, dental, nursing, pharmaceutical, and medical services for evacuees and emergency centres).

7. Medical and health supplies for civil defence.

8. Morgue and burial services.

9. Epidemiology, including health statistics.

The working parties will be composed of persons who have special knowledge in the field under consideration and the members of the party will be provided with basic information before meeting as a group. In addition, a member of the civil defence health planning group of the Department of National Health and Welfare will sit with each working party to assist in integrating the particular problem under discussion with the over-all plan. The first working parties were slated to begin detailed study early this month and it is hoped that the whole program can be covered fairly rapidly by this method of approach.

—*Courtesy Dept. of National Health and Welfare.*

* * * *

Traduction

Le ministère de la Santé nationale et du Bien-être social se chargera de renseigner le général F. F. Worthington, coordinateur de la défense civile, sur les questions d'hygiène et de bien-être. Dans ce but, le ministère va entreprendre et co-ordonner, sur le plan fédéral, des plans relatifs à l'hygiène et au bien-être, dans leur rapport avec la défense civile.

Le ministère a pris des mesures préparatoires, comme la formation du personnel et le rassemblement de renseignements de base sur la question. On a formé un comité de coordination, composé des personnes suivantes: G. D. W. Cameron, M.D., G. F. Davidson, M.D., H. A. Ansley, M.D., R. B. Curry, K. C. Charron, M.D. De plus, on est à constituer un groupe d'organisation sanitaire, dont le personnel travaillera soit à

temps complet soit à temps partiel. Ce groupe aidera à dresser un plan-type général qui pourra servir de modèle aux provinces et aux municipalités qui s'intéressent à l'organisation des services sanitaires de la défense civile. Le Dr. K. C. Charron en aura la surveillance.

Les associations professionnelles et les organismes bénévoles nationaux qui s'intéressent aux divers aspects de ce programme seront invités à coopérer et à participer à ce travail d'organisation. De plus, on tirera tout le parti possible des divers services spécialisés du ministère de la Santé nationale et du Bien-être social, ainsi que d'autres organismes fédéraux.

On formera de petites équipes qui seront chargées d'étudier divers aspects des services sanitaires de la défense civile, tels que:

1. Les services d'évacuation de la défense civile (premiers secours, ambulance, hôpitaux d'urgence, et cetera);
2. Les aménagements sanitaires;
3. Les facilités de laboratoire;
4. Les problèmes d'hygiène alimentaire;
5. Les services médicaux industriels;
6. Les services de santé spéciaux (tels que les services de pédiatrie, d'obstétrique, d'hygiène, mentale, de dentisterie, de soins, de pharmacie et de médecine pour les évacués et les postes d'urgence);
7. Les fournitures médicales et sanitaires pour la défense civile;
8. Les services de morgue et d'enterrement;
9. L'épidémiologie, y compris la statistique d'hygiène.

Les équipes seront composées de personnes qui sont des spécialistes en la matière. Avant de les constituer en groupes, on communiquera aux membres des équipes des informations de base. En outre, un membre du groupe de l'organisation sanitaire de la défense civile, groupe relevant du ministère de la Santé nationale et du Bien-être social, siègera sur chaque équipe, afin d'aider à intégrer dans le plan global tous les problèmes particuliers à l'étude. Les premières équipes devraient être en mesure de commencer, dès le mois de mars, cette étude détaillée. On espère, par ce moyen, examiner assez rapidement le programme en son entier.

The Lengthening Life Span

THE purpose of this article is to present a few statistical highlights on the problems created by the *lengthening life span*—to note essential changes in mortality, profound changes in population structure, the greater need for medical, hospital, and nursing care at older ages; and, by implication at least, the impact of these facts on the health and medical problems which we must plan to meet.

Mortality Changes

During the past 50 years, outstanding reductions in mortality have been made in Ontario. These reductions have been largely in the mortality from a comparatively few causes—spearheaded by the reductions in maternal mortality, in infant mortality, and in the mortality from diphtheria, tuberculosis, typhoid fever, respiratory diseases, rheumatic heart disease, and appendicitis.^{1, 2, 3*}

Deaths from the infectious and communicable diseases in Ontario, for example, have been reduced by 90 per cent during the past 50 years. Deaths from diphtheria declined from 772 in 1901 to 10 in 1948; deaths from typhoid fever fell from 500 in 1901 to 4 in 1948; deaths from tuberculosis dropped from 3,243 to 825. This has been achieved by the collective effect of a number of causes, including improvements in medical care, personal hygiene, education and housing; new discoveries in chemotherapy.⁴

The mortality changes have been characterized by a marked decline in mortality rate in all age groups under 50 years—that in the 40-49 group amounting to two-fifths of the

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rate in 1900; in the 30-39 age group to almost two-thirds; and in all age groups under 30 to fully three-quarters of the rate in 1900.[†]

By contrast, the total death rates in the age-groups 50-59 and 60-69 years have, until quite recently, shown very little change. This fact may in part be due to the sub-standard people in these age groups saved from earlier death by the factors which have combined to reduce mortality at ages under 50 years. There is no justification, however, for "the cynical notion that the causes of death after age 65 are not of great importance". In due time the "preservation of life at 70 will take its rightful place as no less important than was the saving of a life at 50 half a century ago".⁴

Expectation of Life at Birth

The expectation of life or average length of life expresses the mean duration of life to be expected by newborn infants or by people who attain a given age, or the average number of years that a person of a given age will probably survive—on the assumption that the death rates will not change.

The average duration of life has progressively increased from ancient times, but it has increased more in the past century than in all prior centuries since the dawn of civilization.

The average length of life of pre-historic man was perhaps 18 years.⁵ Longevity in Roman Egypt about two thousand years ago has been estimated by Karl Pearson to have been about 22 years. Figures for the Middle Ages suggest an expectation of life at birth of possibly 35

years. According to life tables, constructed by the eminent statistician William Farr for England and Wales covering the period 1838 to 1854, the average length of life had then increased to 40.9 years, a gain of a little more than five years over the figures for the Middle Ages. In the United States, the average length of life rose to 49.2 years in the period 1900-1902.

Spectacular gains have been achieved during the first half of the twentieth century and in 1947 the expectation of life at birth in Canada was 65.2 years for males and 69.0 years for females.

To express this fact in a different way, under the mortality conditions which prevailed in 1900, a group of 100,000 male babies born in 1900 would be reduced to 39,245 by the time they reached their 65th year, while with the death rates of 1947 the number of survivors at age 65 in Canada would be 64,604. In other words the chances of a boy born in 1900 celebrating his sixty-fifth birthday were less than 40 in 100. In 1947 the chances were 65 in 100.⁶ For females the chances are 72 in 100.⁶ Under prevailing mortality rates, half the girls now being born will live to age 75 and half the boys to age 72.^{7, 8}

During the last 50 years the expectation of life at birth has improved by 17 years for boys and by 18 years for girls. In 1900, a young man of 18 had 51 chances in 100 of surviving to 65; in 1948 this figure was 70 in 100. Medical and public health leaders could hardly have expected such gains within two generations. Even in the last 15 years the average length of life has increased by 5 years for males and by 7 years for females.

Expectation of Life at Various Ages

Most of the gain in expectation of life has been made at ages under 50.⁹ There has been comparatively little gain in the expectation of life in the age groups 50 and over. The expectation of life at age 65 is greater in males now only by one year than it was in 1900; in females it is greater by only 2 years.

The mean duration of life to be expected among baby girls born in Canada in 1947 was 69.0 years; at age 50 the expectation was 26.3 years. The average length of life

Adapted by the author from an address presented by him at the Twenty-fifth Annual Meeting of the Registered Nurses Association of Ontario, Toronto, April, 1950.

* References are to bibliography on page 64.

† Ontario figures.

remaining to Canadian males at age 65 is 13 $\frac{1}{4}$ years; for females, 14 $\frac{1}{2}$ years. The more vigorous will of course live much longer than the average.

In countries in which the health standards are high, the expectation of life at birth is not far from the biblical three score years and ten¹⁰. The best records are found in New Zealand, England and Wales, Australia, Denmark, Sweden, United States. The expectation of life at birth in India in 1931 was slightly less than 27 years, not much higher than that estimated for Rome some two thousand years ago.

The Future Outlook for Longevity

The outlook seems favourable for further gains in the expectation of life in the future. We still have a higher infant mortality rate than in England and Wales, United States, Sweden, Holland, New Zealand, and Australia. Wider application will be made of existing knowledge in medical and sanitary science and further advances will be made too in our standard of living, nutrition, housing conditions, protection against occupational hazards and accidents.¹¹ All these forces can effect further reductions in mortality and thus improve longevity¹². Discoveries in the fields of cancer and the degenerative diseases would add significantly to the present average length of life.¹³

Changes in Population Structure

Control of diphtheria, typhoid, smallpox, tuberculosis and other communicable diseases; better medical care; better education; better working conditions; better nutrition, hygiene and sanitation; all the forces mentioned have been responsible for a lowered mortality, a greatly increased life expectancy, and for a profound modification of our population structure, which influences the whole picture of health and disease and which will affect the whole structure of our society.

Until fairly recent decades our population was characterized by its youthfulness. Heavy immigration of young men and women and high birth rates swelled the proportion of people in the younger age groups and diminished the relative importance of those in the age group 65 years and over. Subsequently immigration was reduced, our birth rates

declined and life conservation at the earlier ages brought more and more of the population into the older age brackets¹⁴.

There is no arbitrary boundary between senility and old age. Many people at 65 are still vigorous and gainfully employed, while others are showing signs of ageing. For convenience, the terms "old" and "aged" may be associated with those who have attained their 65th birthday.

Our old people are increasing at a substantial rate. In 1901 there were 269,000 persons aged 65 and over in Canada; in 1921 this had jumped to 419,000, and by 1941 to 768,000. It is estimated that in 1951 the numbers will increase to 1,016,000 and by 1961 to 1,285,000¹⁵. The number of people in the age group 65 and over has doubled in the last 25 years.

Expressed in another way, in 1901 only 50 persons in every 1,000 were 65 years of age or over. In 1931, the figure was 56 and now it is close to 80. By 1971, it is estimated that 11.0 per cent of our population or one in 9, will be 65 years of age or over. This will be a 50 per cent increase in 25 years.

Another important effect of the reduction in our mortality rates is the greatly increased number and proportion of the population who survive to begin and to complete the working years of life. This tremendously important point is often obscured by the emphasis placed upon the problems of "old age". The improved mortality rates at all ages under 50 years ensures us a greatly increased number of years of productive work.

The greatest proportionate increase in our population is in the

age group 45-64 years. In 1901, 745,000 persons or 14 per cent of our population were in the age group 45-64 years. When the 1951 census is taken we may expect to find 2,455,000 persons or 19 per cent of our population in the age group 45-64 years, and 1,016,000 or one in every 13 persons 65 years of age or over. By 1961 we will have something over 2,908,000 persons in the age group 45.64 years, and over one million at 65 years of age and over.

The Health of Old People

At the beginning of the century, the first and second ranks among our causes of death were held by tuberculosis and pneumonia. These two causes accounted for over one-fifth of the total mortality. Since then, they have fallen to sixth and seventh place and now contribute barely one-fourteenth of all deaths. Today, cardiovascular renal disease and cancer account for two-thirds of all deaths.

The age picture of mortality has also greatly changed. In 1900-02, only 43.2 per cent of all deaths were at ages 50 and over—today over 75 per cent fall into these age groups.

In 1943-1947 diseases of the cardiovascular renal system (47.6 per cent), cancer (15.1 per cent), accidents (3.6 per cent), diabetes, pneumonia and tuberculosis caused 74 per cent of the deaths of persons at 60 years of age and over. Two-fifths of all deaths were attributed to diseases of the heart and coronary arteries.

The diseases which account for the majority of deaths in the older age groups are chronic or degenerative rather than acute or infectious. Their incidence is long term and

Table I
Frequency, Prevalence and Severity of Illness*

Age Group	% Disabled on Day of Survey	Disabling Illnesses per 1,000 Persons	Days Lost per Case	Days Lost per Person
Under 15	4.2	232	26	6.0
15-24	2.5			
25-64	4.4	144	63	9.1
60 & over	12.1	265	123	32.6
ALL AGES	4.5	172	57	9.8

*From the National Health Survey, United States, 1935-36.

relatively unvarying. Concerted efforts to reduce them have been started only fairly recently. While the expectation of life at age 50, 60, and above remains approximately the same as 20 or even 50 years ago, the health of old people as a group has already improved and it is inevitable that in the future we shall reduce the causes of invalidism at older ages, even simply as an indirect effect of accomplishments at ages under 65.

The Public Health and Medical Issues

The tremendous increase in the number of individuals age 65 years and over stresses the importance of being prepared to meet the medical, nursing, and related needs, which such changes in population structure are bringing.

The seriousness of the medical and nursing issues involved in our lengthening life span are emphasized not only by the greatly increasing numbers of persons at older ages but by a number of established facts in sickness and hospitalization experience¹⁶. These are worthy of brief reference:

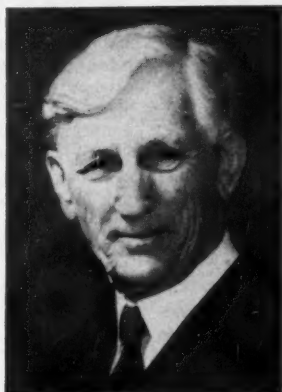
1. *Incidence of Illness.* The incidence curve of illness is similar to that for mortality. The incidence of illness changes little from 10 to 44 years but rises steeply after age 60.

2. *Prevalence of Disabling Sickness.* The percentage of persons disabled by sickness or injury at ages 45-54 is twice, and at ages 55-64 years is three times what it is at ages 15-44 years. About one person in 8 over 65 years of age suffers from some form of disability. Illnesses causing disability for a week or more involve 28 per cent of older people each year (Table I).

3. *Disability Rates.* The duration of disability or length of stay in hospital both increase three-fold at the older ages. The number of days of disabling sickness per person at all ages is 9.8 days. At ages 65 and over it is almost 33 days¹⁷.

4. *Chronic Disease.* There is a steep rise in the prevalence of chronic disease with age. At ages 70 and over the figure is 5 to 6 times what it is at younger ages.

5. *Invalidism.* The number of



Frederick William Routley, M.D.

A WELL known and highly honoured Canadian was lost to the health field in the death of Dr. Fred Routley on February 11th. Dr. Routley had been associated with the Canadian Red Cross Society for 27 years and, prior to his retirement two years ago, had been National Commissioner for 11 years. Not the least of his accomplishments in that capacity was the establishment of numerous outpost hospitals in the frontier areas of Canada and more than 100 highway first aid posts.

During those same years, Dr. Routley served as secretary-treasurer of the Ontario Hospital Association and was in large degree responsible for the rapid development and progress of that organization. He has also acted as a director of its Blue Cross Plan for Hospital Care.

When the need for a central organization representing all hospital groups became apparent, Dr. Routley was among those who established the Canadian Hospital Council in 1931. He was chosen as the Council's first president, a position which he retained for four years. Last year, the executive of the Canadian Hospital Council bestowed upon him the George Findlay Stephens Memorial Award in recognition of his years of service to the hospitals of Canada.

His many friends and colleagues in all provinces, as well as abroad, will long remember with appreciation his multitudinous good works and, in particular, the ever-friendly smile and constant good will of the astute "Dr. Fred". A fitting tribute to these qualities was paid to Dr. Routley at the last Ontario Hospital Association convention. To mark his 25 years of service with that organization, a morocco-bound Volume of Friendship, containing many personal letters of appreciation written by his associates in the health and hospital field, was presented to him.

Dr. Routley is survived by his wife, the former Gertrude Fry; a daughter, Mrs. Arthur E. McKennedy; and four brothers, Frank, James, Al, and Clarence.

invalids in the population (persons permanently disabled by chronic disease) varies sharply with age also. In the population as a whole the rate is 11 per 1,000. At ages 65-74, the figure is 55.0 and at 75-84, it is 76.1. Probably 70 per cent of our invalids are at ages 50 or over.

6. *Medical Consultations.* An individual consults his physician 300 times in his lifetime—5 times per year at all ages for each sex. At ages 65 and over the consultation rate is twice what it is at ages 15-44 years¹⁸.

7. *Hospital Utilization.* There is a substantial increase in the average length of stay per case with increasing age, from age 50 on¹⁸. For every day of hospital care required per 1,000 population at ages under 65 years, two days are required at ages 65 and over.

The steep increase with age in medical calls, disabling illness, chronic disease, invalidity, and hospital bed requirements, clearly indicate that since the medical problems of older ages are now relatively much more important, the medical, nursing and hospital demands to be met in the future will be, to say the least, sizable!

Every practising physician has felt the impact of the changes in age structure of the population in recent years. The weight of this impact is going to increase by 25 per cent in the next ten years! The pattern of disease incidence and mortality has shifted to feature the conditions of the older ages and those of a more chronic character. The Metropolitan Life Insurance nursing experience of 1925 showed that 50 per cent of the cases were nursed for acute medical conditions and only about 5 per cent for chronic diseases¹⁹. In 1945 on the other hand the two figures were 14 and 28 per cent respectively—a complete reversal of emphasis.

While there are more cases of cancer, heart disease, et cetera, in the population today, a person aged 65 today is no more likely to develop heart disease, hypertension, arthritis, diabetes, or cancer, than he was 30 or even 50 years ago. The situation is simply that the person is more likely, if he develops the disease, to survive to the age of 65.

Hospitalization

Trends in hospitalization have been steadily upward over the years. Approximately one-third of the case load involves persons 60 years of age and over among whom cancer, diabetes, peripheral vascular disease, cerebral vascular accident, fractures of the hip or femur, prostatism, and senility predominate²⁰.

The facilities for caring for illnesses in the home have a decided influence on the request for hospital admission. Congestion in urban areas with multiple families in one dwelling often makes it extremely difficult to care for even the most minor illnesses. Such difficulties are accentuated by the lack of available help within the home²⁰.

Mental Hospitals

The vast problem of mental disease is perhaps the most serious in the entire health field. The number of patients in mental hospitals in Canada has increased from 31,701 in 1931 to 49,163 in 1946. In 1946 there were 399 patients in mental hospitals in Canada per 100,000 population.

The admission rates for mental disease are low at ages under 15 years and change very little from age 20 to age 65; in the age groups beyond 65 years the rate is twice what it is in the younger age groups or at middle life.

The figures for the Province of Ontario show that although only 9 per cent of the population is 65 years of age and over, 18 per cent of all the mental hospital beds are occupied by persons at these ages; an additional 37 per cent are in the age group 45-64 years. For Canada, as a whole, 19 per cent of all first admissions are 65 years of age and over and of these, 80 per cent are patients with senile psychoses or psychotics with cerebral arteriosclerosis. There are many more of these patients not in hospitals but for whom some additional provision is required.

Facilities for Chronic Disease and Disabling Illnesses of Old People

It is our pressing medical problem to provide adequate medical care for the large and increasing numbers of aged sick and persons suffering from disabling chronic conditions.

Although chronic diseases find the

majority of their victims at older ages, the term "chronic sick" includes all age groups: infants and children with congenital heart disease, rheumatic heart disease, orthopaedic conditions; adults with tuberculosis, progressive nervous diseases; older men and women with arthritis, cancer, arteriosclerotic and cerebral vascular changes, and senile conditions of all types.

It has been said that the chronic aged sick have been inadequately cared for in the past and often receive scant attention²¹. Certainly our few hospitals for chronic diseases are filled to overflowing and many patients in need of institutional care must wait until beds are available. In addition, there is a pressing necessity for a larger number of beds for the care of aged invalids and semi-invalids.

Perhaps the most important single limiting factor today in relation to the care of the aged is the shortage of nursing staff. The potential source of nurses is the female population 17-20 years of age. The number of young women in this age group have been decreasing in absolute numbers since the late thirties and will not begin to turn upward until 1955 nor get above the present level until 1958. The ratio of females 17-20 years to total population has declined steadily from 1939 and this proportion will probably not regain its pre-war level until 1963-65. These facts pinpoint the nurse-power problem today.

Classification of the Aged Chronic Sick

The whole question of the management and care of the chronically ill, the aged sick, and the well old people is under review in many quarters. The Nuffield Trust Report on "Old People"²², the British Medical Association statement regarding the care and treatment of the elderly and infirm²³, and the Report of the New York State Joint Legislative Committee on the Problems of the Ageing²⁴, among others, have emphasized the need for:

- (a) Specific provision of hospital beds for those who may be classified as active chronically ill, i.e., requiring active medical care. This might be effected by separate hospitals or by units in general hospitals (Geriatrics units).

(Continued on page 62)

*A Special Activity for
National Hospital Day*

CAREER NIGHT

WHY not stage a "hospital career night"? It can work in every community that has a high school full of boys and girls. The hospitals and the whole health field need the best young brains and bodies in order to meet the bigger and more complex task of hospital care. We take great pains to select good supplies and equipment, but what is the advantage if we do not set out to recruit staff of comparable quality? What would be involved in a hospital career night? The following points might be observed in planning such an event.

Choose a Date

National Hospital Day, May 12, would be an ideal day for a *career night*. It need not interfere with other Hospital Day activities, rather it would supplement them. It will be on a Saturday night, which is a natural for a teen-age "do". It will give the high school group a bit of relaxation from the pressure of examinations and they will appreciate it.

Set up a Career Night Committee

This committee should not be too large nor too small. Select a couple of young student nurses, very recent graduates, or young technicians, who have the teen-age outlook. One or two members of the women's hospital auxiliary may be able to give some tips on refreshments. A high school teacher or vocational director or counsellor would be very helpful. Choose, also, one of the medical staff who has a son or a daughter. Then round out your committee from your staff and community to suit the needs of your program. Would it not be a good idea to add one or two class representatives from the high school(s)?

Co-operation with Other Hospitals

If there are several hospitals in the community, it can be a joint or

co-operative undertaking. This would be simpler than trying to divide the high school or schools among the hospitals. And furthermore, the spirit of co-operation among the local hospitals would not be lost upon this group.

Arrangements

Bring career night to the attention of the prospective junior and senior matriculants at least a month in advance. Bring it to the attention of boys as well as girls, for there are many hospital opportunities for the lads too. A nicely engraved or printed invitation mailed to the home address of each student would cause a real stir. And put a notice in the school paper or have one of the sororities or clubs at the school promote it. Do not miss the local press and radio for both have teen-age readers and listeners.

If the auditorium at the hospital is big enough, use it, for it would be convenient. However, it may be necessary to use the school auditorium or gymnasium, or the town hall. In any case, the place selected should be large enough and should have a spot where refreshments can be prepared—very important to the growing person. One of the soft drink companies may realize the value of the opportunity.

Program

The backbone of the program should be demonstrations or displays pertaining to the many opportunities. These can be handled in separate booths or corners by those trained in the many different phases of hospital work. They are: nurses, nursing assistants (male and female), medical record librarians, radiographers, laboratory technicians, dietitians, medical social service workers, business and admitting office staff, pharmacist, engineering and maintenance trades, occupational therapists, physiotherapists,

and so on. Each display must be attractive and not too technical.

Be careful not to have too many speeches or long talks. A good film might be appreciated. An appropriate amount of entertainment interspersed at proper points will clinch the evening. Then add some dancing or a good local entertainer and, of course, a good lunch.

The above are merely suggestions; a good committee can do wonders.

Expenditure: A bit of time and energy and a pinch of interest by hospital people.

Income: First, an enthusiastic group of young supporters in the community and, by the way, some choice recruits to the health field for the summer holidays—and a good opportunity for a try-out; secondly, a life-time career in the hospital and health field for peace (and in case of war).

Balance Sheet Analysis: Accumulating assets.

With just under two months to get this public relations effort lined up, let's roll!—L.O.B.

The current issue of *Canadian Home Journal* carries an article by Max Braithwaite under a scare headline "This Shortage May Kill You". This unfortunate choice of title will arouse lay curiosity and a good deal of anxiety. It might be well to glance through the article, for your own information.

Questionnaire Prepared for Hospital Dietitians

At a recent meeting of the Executive of the O.H.A. Dietetic Section, it was learned that a questionnaire had been prepared as a follow-up to a resolution passed by the Dietetics Section at the O.H.A. Convention, Oct. 30-Nov. 1, 1950, (see *The Canadian Hospital*, December, 1950, page 64). The resolution "Resolved that the need to have the nutrition questions on the Reg.N. examinations set by a qualified dietitian be considered a matter for action", forms the basis of the questionnaire which will be sent to all dietitians in hospitals having Nurses' Training Schools. At present it is planned to summarize the results of these questionnaires at the next annual meeting of the section.

Food and Its Service

Sponsored by
the Canadian Dietetic
Association

IN February, 1950, a new maternity pavilion was opened at our hospital and, as did many Canadian hospitals in the past decade, we experienced certain growing pains. The expansion of our institution from 80 to 200 beds obviously brought many changes and particularly required an enlarged dietary service.

In planning an addition to a building, architects meet challenging problems which are not encountered in making blueprints for entirely new construction. In our case, the ultimate plan was to provide quarters for a main kitchen and subsidiaries in a one-storey section between the west wings of the new and old building, with cafeteria for staff on the ground floor of the new pavilion. This arrangement gives us a very pleasant view of the Charlottetown Harbour both from our kitchen and dining room, with the added enjoyment of delightful, cooling breezes which are wafted over the waters on even the hottest days. The design also provides an abundance of overhead lighting and ventilation for the kitchen and often provokes the visitor's remark of "How bright your kitchen is!"

At the entrance to the main kitchen we have a lavatory basin to encourage employees to wash hands before beginning work. Located in the cooking area are an insulated cooker, an electric roast oven, a steam cooker, two steam jacketed kettles, (one twenty-five, one thirty gallons), a cereal cooker with 2 four-gallon containers, steam table, hot water urn, chef's table, et cetera. On the right is the vegetable preparation area with double compartment custom-built sink set 28" from the floor. The mechanical parer, raised on an extension, empties peeled vegetables directly into the right hand sink (36" x 24" x 6"). The worker who finishes vegetables may sit here on a low stool or chair and drop completed products into left hand sink (26" x 24" x 14"). All these arrangements were designed in

an effort to implement the late Violet M. Ryley's oft-repeated advice concerning the comfort of workers.

The vegetable sink is of moulded stainless steel as is the pot sink on the opposite side of the kitchen. Perhaps Keats would not feel as I do but to me each is "a thing of beauty" and I hope, "a joy forever". I am sure no walnut what-not in a Victorian parlour gave more pleasure than this dietitian finds in looking upon the stainless steel pot-rack adjacent to its sink.

The refrigerator has a reach-in

A Visit to a New Hospital Kitchen

Sister Frances Loyola, C.S.M.,
Dietitian,
Charlottetown Hospital,
Charlottetown, P.E.I.

section for the conveniences of cooks and the walk-in has dairy, meat, fruit, and deep-freeze compartments. A salad section kept at about 45° Fahrenheit is placed so that it may be used by main kitchen or special diet kitchen. Special refrigeration is provided for garbage outside the kitchen area.

A good deal of consideration was given to central versus decentralized food service. It was finally decided to continue the type of service we had been using, namely to send food to floor servery in heated conveyors. This had enabled us to serve hot foods hot and we hope to continue to do so.

Trays are returned on angle steel conveyors to the dishwashing de-

partment. Soiled dishes are passed through a window to the dishwashing center. A pre-rinse sink is provided in the scraping table, and after rinsing, washing, and sterilizing, the clean dishes go through to the area where trays are set up and placed again on their conveyors. This plan has reduced noise on the floors but, alas, not in the kitchen area. However, "The patient comes first" is a hospital motto and we sacrifice our comfort to his.

We have room numbers engraved on silver sugar bowls so that each patient always uses the same bowl. We use individual glass pourers with chrome tops on trays which do not have silver service. So that tray settings may be intact when serving time comes, tray conveyors are not returned to servery until shortly before meal hours. Aluminum dish trucks are used to take the plates, cereal dishes, et cetera, which need heating, directly to servery to be placed in warming cabinets.

Our bake room is a separate unit which is glassed in above the wainscoting. Here desserts, pastries, rolls, raisin loaves, et cetera, are made, but we do not bake our own bread. A 2-deck electric bake oven gives satisfactory service as it did for 7 years in our former kitchen. A mixer with 30 and 60 quart bowls and a jacketed kettle are also in this department and a proofer will be installed later. The dietitian's office is between the special diet kitchen and main kitchen.

The special diet kitchen is spacious and is used by student nurses for laboratory purposes. It contains a hand basin, a small steam table, a 28 cubic foot refrigerator, an electric range, tray rack, sinks, tables, cabinets, and a desk. Two student nurses are sent here each month for practical work. Adjacent to this kitchen is the formula room with sterilizer and complete equipment. Formulae are prepared here for nursery and paediatrics.

The staff dining rooms have 20 formica-topped chrome tables, each

seating four persons. Since the some 120 diners come at different times for meals there is never overcrowding. The self-service cafeteria with stainless steel equipment is very satisfactory. Dishes are washed in the central dish washing department.

I pause here to say that in our planning we had much appreciated co-operation from our Board of Governors and I trust that the equipment provided us will be here for many years as a testimony to their vision. Stainless steel is very expensive, especially in the eyes of those unacquainted with the heavy duty demands in institutions.

I know that many members of the Canadian Dietetic Association are experienced in planning efficient dietary services, although very few can manage to have the ideal kitchen of their fondest dreams, since monetary consideration, architects' ideas, and many other factors often interfere. However, one can learn a great deal in helping to plan a dietary department and I would like to mention a few points which I found to be important.

1. The exit from the dishwashing table must be 32" wide to allow for the return of racks. (The older type of dish-washer did not require this.)

2. The dwarf wall providing electric outlets for food conveyors,

which is finished in plaster, is being continually damaged by sharp corners of covers, et cetera.

3. Anxious to get the department finished, I allowed installation of a single compartment sink that was on hand in the special diet kitchen instead of waiting for the double compartment one specified. I was not working here two days before I realized what a nuisance it is.

Perhaps Maritimers with institution building problems would like to visit us. I assure you that our administrator and all the staff are

glad to share experiences with other hospital workers. In regard to personnel, we found one special problem when we enlarged the dietary department. Workers had to be retrained to cope with larger services since traditional methods have a way of sticking even when they are no longer correct.

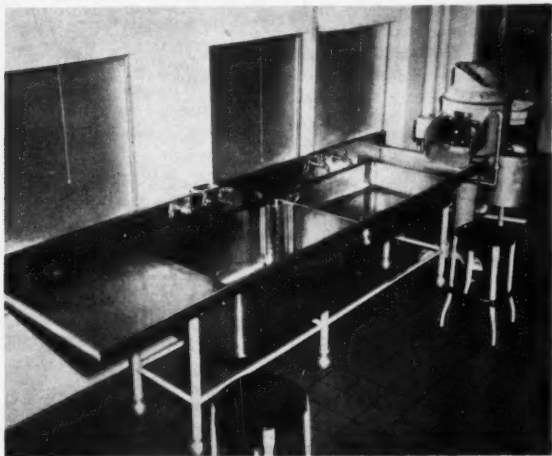
The 24-hour service demanded of hospitals applies to dietary services as well as nursing and medical care and requires not only a well-equipped kitchen but also a dietitian or dietitians with a long list of perfections. In our efforts to live up to the ideals of our profession, let us not grow weary. Let us keep in mind the Master Provider who did not neglect the bodily hunger of people around Him and who promised generous rewarding to those who give even a cup of water in His Name.

More Vegetables!

From a summary of nine dietary surveys done by the Nutrition Division in various areas in Canada, it was found that three out of four of the people had at least one serving of potatoes a day, but that only one out of five had the daily recommendation of two other vegetables. These results seem to indicate that more emphasis should be placed on increasing our vegetable consumption.—"Nutrition Notes", Feb., 1951.



Exterior view of the new kitchen. Note the type of windows for overhead lighting.



This gleaming vegetable preparation sink is set 28" from the floor for the convenience of workers.

THE National Health Service started in an atmosphere of friction, controversy, misunderstanding, doubt, and hope. It has been in operation for some two and a half years, and the beginning of a New Year is opportune to take stock of the position of the five elements mentioned, the first four remain in full strength—the last named, hope, is dying fast.

The object to be achieved, as stated in the Act, is the provision of a comprehensive health service. Has it succeeded? We doubt if anyone, not excluding the Minister of Health himself, would be prepared to say it has. True, millions of people have been supplied with artificial dentures, spectacles, bottles of aspirin, hot water bottles, corsets, et cetera, but so far as the hospitals are concerned the position is very much as it was. The shortcomings continue and serve to increase the earlier irritation and frustration.

The original unwieldy set up, with its over-centralization, has been proved to be top heavy and extravagant and, until the reins are loosened, the central authorities will fail to create that spirit of co-operative enthusiasm which is essential to the smooth working of a service where the human element is such an important factor. Many who were enthusiastic about the scheme when it was introduced are now among its severest critics. The unsympathetic attitude of the central authorities, and their attempts to regiment the service, is causing considerable concern in hospital circles. The "forced" transfer of two cottage hospitals in face of strong petitions and the rejection by the Minister of requests for an enquiry show to what lengths authority will go to secure its ends. We are not concerned with the merits of either case. There may or may not be good reasons for the transfers. We are, however, concerned with the manner in which proposals are forced through against the wishes of the public which the hospitals serve.

We have had a sit-down strike of porters of a hospital. The secretary of the National Union of Public Employees admitted that his union realized it was a bad thing for hospital employees to strike, but it was

Taking Stock

(An editorial appearing in "Hospital and Health Management", London, Eng., January, 1951).

necessary to do so to bring to the notice of the public the conditions under which they work, and, he added, "since the start of the National Health Service things have got far worse".

The hope, that as the service settled down the earlier irritations and frustrations would disappear or become less in evidence, has failed to materialize. Frustration takes many forms. On the higher level it is caused by the attitude of central authorities towards the hospitals management committees. Regional hospital boards are continuing their efforts to control these committees to an extent which makes it difficult for them to carry out effectively the management of their hospitals. On a lower level it is caused by the attitude of committees to their executive officers. Many committees require that every matter shall be brought before them for discussion and decision. Prior to the Act, executive officers of a hospital were endowed with adequate authority to deal with numerous day-to-day routine matters which now have to be submitted to this or that committee. Attendance at an almost endless series of meetings and the lack of authority commensurate with their positions are turning these officers into glorified clerks and killing their initiative and enthusiasm.

Hospital finance is still on an unsatisfactory basis. If a hospital, by good management, saves a few thousand pounds on its budget, it must return the amount saved to the Exchequer. Budgets are still required to be prepared some six months in advance! Although it is claimed that 14,000 more hospital beds have been made available since the Act came into operation, it is more difficult to secure admission to a hospital. A period varying from three to six months is not unusual, and many persons prefer to make

private arrangements rather than wait so long for treatment. Some 11,000 patients are awaiting admission to the 23,000 beds available for the treatment of tuberculosis. . . . Registrars are to be cut from 28,000 to 1,700! This direction by the Minister raised a storm of protest, and it is of more than passing interest to note that the Socialist Medical Association protested more vehemently than any other body and issued a memorandum calling for the withdrawal of the order.

The present position is obviously far from satisfactory. The Minister has created a machine instead of providing a service; an unwieldy, top-heavy, and expensive machine. Can it be reconstructed in such a way that friction, controversy, misunderstanding, and doubt are removed, and hope revived? It can, but only if the central authorities will realize that they hold their respective positions to provide a service to the public. They cannot expect to secure the whole-hearted co-operation of the hospital unless they ease the reins and give the horse his head. The horse, by reason of long experience, knows the way, but he can not take it if the bit is held too tightly.

The country is paying a huge sum of money for an incomplete and unsatisfactory service. We express the hope that the New Year will see a welcome change in the attitude of the central authorities to the end that the enthusiastic co-operation of all concerned with the development of the hospital service will be secured. With this co-operation, all the irritations and frustrations will disappear, and something approaching the spirit of the old voluntary hospitals will take their place. Without this spirit the service will never succeed.

The Seven Stages of Man

1. Milk
2. Milk, vegetables
3. Milk, ice cream sodas, candy
4. Steak, coke, french fries, ham and eggs.
5. Frogs' legs, caviar, crepes suzettes
6. Milk and crackers
7. Milk.

—The Santa Fe Magazine.



New wing of reinforced concrete and brick.

THE new wing of St. Mary's Hospital at Trochu, Alberta, was officially opened in July, 1950, by Archbishop J. H. MacDonald of Edmonton. This extension to the hospital, whose humble beginning in a granary dates back to 1909, pending a more substantial building in 1911, brings the total capacity to 29 beds and six nursery cubicles. Of reinforced concrete and brick, the four-storey structure was designed by Rule, Wynn, and Rule of Calgary, and built at an approximate cost of \$185,000.

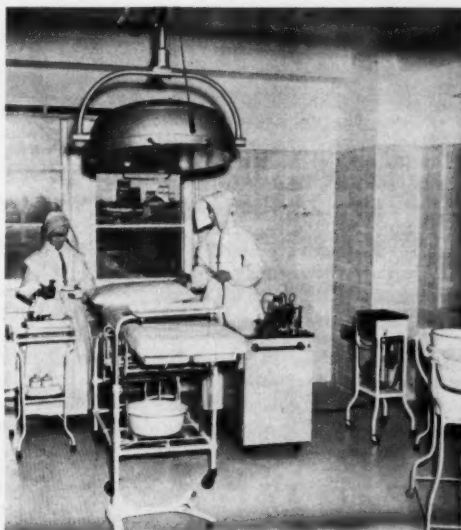
Patient accommodation is on the first and second floors only. The whole third floor is made into single, double, or multi-bedrooms, for the female staff and the sisters with each group having its own bathroom. All dining-rooms are in the basement, as well as the male employees' bedrooms, the girls' washing and ironing rooms, and a storage room.

On each patient floor a sitting room has been provided for the use of visitors and ambulatory patients; while a rest room for the use of the lay staff is located on the third floor.

All floors throughout the extension are of concrete covered with linoleum, except in the operating room, case room, and sterilizing rooms, where ceramic tile has been used. There, too, ceramic tile in soft tones has been used on the walls up to six feet, while the rest is plastered and painted in colours to match the tile. Where linoleum covers the floor, a coved linoleum baseboard has also been used.

Modern Addition to St. Mary's Hospital

Trochu, Alberta



Operating room on first floor.

Noise has been minimized by the use of acoustic tile ceilings in all corridors, surgical and obstetrical suites, nurses' stations, information room, and the office. Some partitions have also been sound insulated and all beds and movable equipment have rubber bumpers. The operating suite on the first floor, and the obstetrical suite on the second floor, are well separated from the other departments.

A quiet-moving elevator is located close to the ambulance entrance so that patients may be easily moved from the ambulance to any part of the hospital. Patients also enjoy hot meals, which are carried to them

by electrically heated food conveyors with bumpers.

Part of the old section of the hospital has been retained and renovated to include seven private rooms, a paediatric department, isolation suite, treatment room, and a laboratory. A walk-in refrigerator has also been installed in the basement. Adjacent to the main wing a separate boiler room has been built while the laundry in the old part has been modernized and enlarged.

The new extension is the realization of a long-cherished dream of better accommodation and facilities for the patients which the hospital serves.

◀ Notes About People ▶

Dr. A. C. McGugan Elected A.C.H.A. Regent

Recently Dr. A. C. McGugan, superintendent of the University of Alberta Hospital at Edmonton, was honoured by the American College of Hospital Administrators, Chicago. Dr. McGugan was elected for a two-year term as regent for the College of district 15, which comprises the four western provinces.

Edith L. Elliot Appointed to Department of Fisheries Post

The Department of Fisheries has announced the appointment of Edith L. Elliot, home economist, as chief of the newly-organized Home Economics Section of the Department's Inspection and Consumer Service. Miss Elliot will be responsible for the co-ordination of the work of the Department's home economists and also for the extension of the efforts being directed through the Department's test kitchen, which is to distribute information on the proper methods of buying, preparing and serving fish, shellfish, and other fish products. Prior to joining the Fisheries Department Miss Elliot

was with the federal Department of Agriculture.

Dr. F. B. Roth Appointed to S.H.S.P. Commission

Dr. F. B. Roth, director of the division of hospital administration and standards for the Saskatchewan Department of Public Health, has been appointed to membership in the Health Services Planning Commission. A graduate of the University of Western Ontario at London, Dr. Roth received a diploma in hospital administration from the University of Toronto in 1949.

Pathologist Appointed to Hospital Post at Owen Sound, Ont.

Dr. George Hardy Eagles, of Meaford, Ont., has assumed his new duties as head of the new clinical and pathological laboratories at the Owen Sound General and Marine Hospital, Owen Sound, Ont. Prior to his appointment Dr. Eagles had spent many years in London, England, where he was attached to the Lister Institute.

Dorothy Morgan Accepts Post at University of Chicago Clinics

The appointment of Dorothy Morgan, Reg.N., formerly of London, Ont., as director of nursing of the University of Chicago Clinics, was announced recently. Miss Morgan was assistant superintendent at the Kingston General Hospital before leaving in 1947 to take the hospital administration course at the University of Chicago. Prior to her present position, Miss Morgan was superintendent of St. Barnabas Hospital, Minneapolis, Minn.

Dr. D. W. Crombie Retires from Beck Memorial Sanatorium

David W. Crombie, M.D., has retired from his position as superintendent of the Beck Memorial Sana-

torium at London, Ont., owing to ill health, but will remain as chief consultant at the hospital. Dr. Crombie had been superintendent of the Sanatorium since 1933, and for 20 years previous to this has been on the staff of a private institution, the Calydor Sanatorium in Muskoka. His successor will be Dr. William C. Sharpe, M.B., who has been on the staff since 1927 and for the past few years has been assistant superintendent.

Superintendent Appointed at Brandon General

Allan K. McTaggart was recently appointed superintendent at the Brandon General Hospital, Brandon, Man., and assumed his duties at the end of February. During World War II, Mr. McTaggart served with the Third Canadian Infantry Division, retiring with the rank of Major and the D.S.O. He enrolled at the University of Toronto for a post-graduate course in hospital administration in 1948 and, on completion of an administrative residency at the Royal Victoria Hospital, Montreal, received a diploma in hospital administration in 1950. In July of last year, he was appointed a hospital consultant with the Department of Public Health, Province of Saskatchewan and remained at this post until he accepted his new position at Brandon.



Edith L. Elliot.

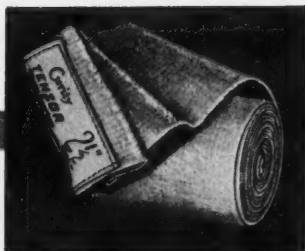


Allan K. McTaggart.



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Notes on Federal Grants

Cancer

An increased demand for radon to treat cancer in Ontario has necessitated the establishment of a new and enlarged radium emanation plant at the Christie Street Pavilion, Toronto. Radon, a short-lived, radioactive gas given off by radium, is used extensively in the treatment of cancers near the surface of the body. Its use reduces the amount of highly-expensive radium required for a cancer control program.

For some years radon seeds have been prepared in a plant in the McLennan Laboratory at the University of Toronto. This installation was designed to operate when not more than 300 milligrams of radium are to be stored. However, public health authorities have found that at least 1,000 milligrams are needed to meet the present requirements of cancer clinics and private physicians. The federal and provincial governments are sharing the cost of the new plant, estimated at about \$18,000.

Construction

Several Ontario hospitals will receive government aid in new construction projects. In Orillia, the Soldiers' Memorial Hospital is being enlarged to accommodate 41 more adult patients and 38 infants. Federal and provincial governments are each contributing more than \$53,600 and construction is to be completed this summer. A new general hospital is being built at Sioux Lookout which will have 40 beds, and a 10-bassinnet nursery. It will serve about 10,000 people in the town and surrounding district and will replace a smaller hospital which is to be abandoned when the new building is completed later this year. The federal grant will be about \$43,300. Hotel Dieu of St. Joseph's Hospital, Windsor, has been awarded \$197,000 to help meet the cost of additional construction. Alterations to the present building and the 5-storey addition will almost double

present capacity by providing space for 178 more beds and a 63-bassinnet nursery, as well as ancillary medical, surgical, and obstetrical services. The new Kitchener-Waterloo hospital, Kitchener, has been awarded a grant of \$434,800. This hospital, to be opened shortly, will accommodate 343 patients, and will have a 76-bassinnet nursery, as well as complete medical, surgical, and obstetrical services. The existing hospital is to be converted to the care of 117 chronically ill patients.

Federal grants totalling about \$27,300 have been allocated to help meet the building costs of health centres or hospitals in Mission City, Lone Butte, and Alexis Creek, B.C.; Hythe, Alberta; and Morse, and Lucky Lake, Sask. At both Mission City and Lone Butte, B.C., extensions and alterations of the two hospitals were actually completed about two years ago but no claims for federal assistance had been entered until recently. In each instance most of the construction had been completed before the national health grants came into effect so that federal payments to these hospitals are calculated on the basis of the amount of work uncompleted on April 1, 1948. Alterations have been made to an old building at Alexis Creek, B.C., which was once used as a hospital. Now operated by the Canadian Red Cross Society, this outpost unit has three beds for emergency cases. Its staff has also organized a service for out-patients and for the home nursing of emergency cases in the surrounding district. The federal grant toward the cost of alterations will be \$3,000.

The hospital at Hythe in the Peace River district of Alberta was partially built when the federal health program began but is eligible for a grant of \$5,800. It is operated as a sub-hospital to Grande Prairie, and serves about 1,800 people in an area of more than 400 square miles. A grant of \$3,850 has been authorized for the new health centre at

Morse, Sask., which serves the eastern part of the Herbert-Morse hospital district. It provides office and laboratory accommodation for a doctor, a dentist, and public health nurses. At Lucky Lake, Sask., a new 12-bed hospital is being built by renovating a former RCAF building. The hospital will be completed shortly and will serve about 3,000 people. The federal and provincial governments are each contributing \$12,000 toward construction costs.

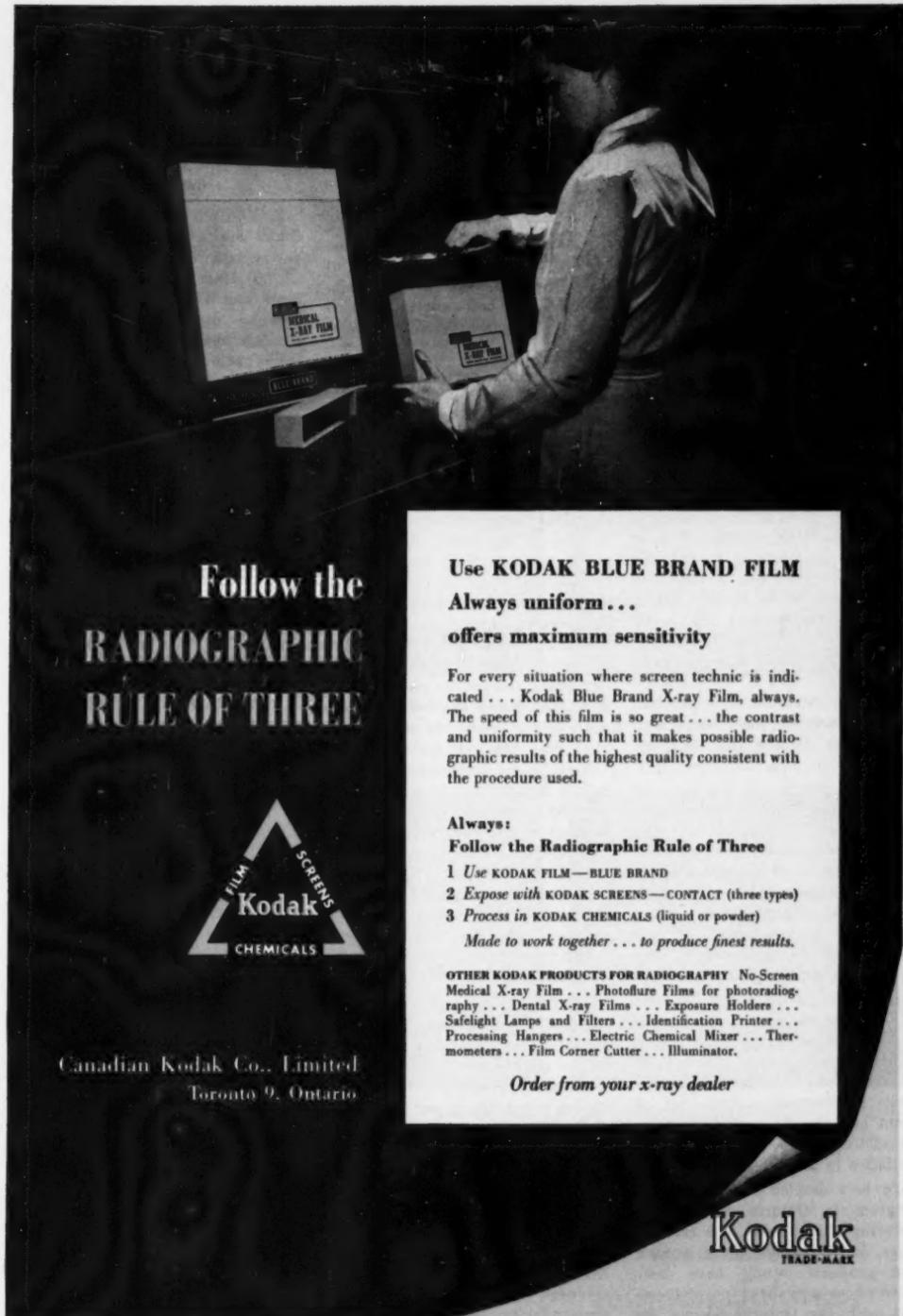
At Sorel, P.Q., the Grey Nuns are building a new hospital to care for chronically ill and incurable patients. Construction was begun before April 1, 1948, and thus a federal grant of nearly \$87,000 has been allotted for work completed after this date. The hospital will have 112 beds, with facilities for medical care, physiotherapy, and occupational therapy. The new building will replace a 74-bed hospital which is to be abandoned and will serve the town of Sorel and the surrounding district in the counties of Richelieu, Vercheres, and Yamaska.

In Perth, N.B., a new hospital, the Hôtel Dieu de St. Joseph is to be built later this year and will serve some 23,000 people in the district. It will have 38 beds, a 10-bassinnet nursery, 2 operating rooms, a pharmacy, and x-ray, medical, and obstetrical services. The federal and provincial governments will each contribute more than \$41,300 and the present hospital facilities will be abandoned when the new building is finished.

Mental Health

To help improve treatment services in Saskatchewan's mental hospitals the federal government has earmarked an additional \$6,400 to buy special technical equipment. At the Saskatchewan Hospital, Weyburn, additional orthopaedic equipment will be obtained to improve the treatment of fractures, and surgical instruments will be bought so that leucotomy operations may be performed at the hospital. Further, funds are being provided to equip a pathological department at the hospital. Teaching equipment will also be purchased for the Munroe Wing of the Regina General Hospital.

Two more treatment units for electro-convulsive therapy will be



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purchased for the Saskatchewan Hospital at North Battleford. Funds have also been earmarked to buy additional equipment for the x-ray department and to increase the hospital's laboratory facilities. The latter are used for testing milk and water supplies and for other public health services in the district as well as for diagnostic and treatment services for the 1,800 patients in the hospital.

Professional Training

Bursaries for post-graduate training have been awarded to several persons in New Brunswick. Two nurses, one from the Moncton Hospital School of Nursing and one from Hotel Dieu Hospital, Chatham, are receiving training in the teaching of nurses and supervision of schools of nursing. A bursary has been awarded to a Fredericton man for a year's study at the University of Montreal, thus enabling him to obtain his doctorate in psychology. On his return, he will be employed in the provincial mental health service. Three persons are being trained for the provincial Bureau of Laboratories. One is taking a year's course in chemistry at Mount Allison University, Sackville, and two are studying medical bacteriology and parasitology at the University of Toronto.

Federal grants will pay the cost of a training course for hospital accountants in Nova Scotia. The course is designed to develop a more uniform system of hospital accounting and is expected to be of particular value to accountants in smaller hospitals. Establishment of the course was recommended by the Maritime Hospital Association.

In Newfoundland money has been set aside to enable a nurse to take a three-months course in the supervision of orthopaedic nursing at Department of Veterans Affairs hospitals in Montreal and district. A grant has also been authorized for the assistant to the registrar of vital statistics to take a short course.

To help develop a rehabilitation program in Ontario for children suffering from polio and cerebral palsy, bursaries for three months' post-graduate study have been awarded to a visiting physiotherapist with the Ontario Society for

Crippled Children, and an occupational therapist at the Woodedden Cerebral Palsy Centre, near London. The physiotherapist will study at the Children's Rehabilitation Institute, Cockeysville, Md., and the occupational therapist at the Variety Club Cerebral Palsy Centre, Buffalo, N.Y. Funds have also been earmarked to give four public health nurses a short course in psychiatric methods, which will include an introduction to mental hygiene, the value of occupational therapy with psychiatric patients, and practical experience in a community mental health clinic.

Eight more persons from the Prairie Provinces have been awarded bursaries or travelling scholarships. In Saskatchewan the director of the Regina Mental Health Clinic has been awarded a bursary for a short course in psychosomatic medicine at the University of Cincinnati; a member of the mental health division's staff has been allotted funds to visit centres in the United States where courses comparable to Saskatchewan's three-year psychiatric training course are operating; and the doctor who is responsible for developing research in mental health in Saskatchewan has been awarded a travelling fellowship in order to visit nine research centres in the United States and eastern Canada before launching into a long-term research program. In Manitoba a member of the staff of the Minnedosa hospital is taking a six-month course in obstetrics and the care of the newborn at the Winnipeg Maternity Pavilion, and a milk inspector with the Winnipeg city health department is enrolled in the University of Manitoba's course in dairy husbandry.

In Alberta an Edmonton doctor is taking a year's post-graduate training in science at the University of Alberta in preparation for specialization in psychiatry and will return to the provincial mental health service on completion of the course. The superintendent of nurses at the Central Alberta Sanatorium has been awarded a bursary to spend three months in the United Kingdom studying methods used in British sanatoria. The course was arranged by the British National Society for the Prevention of Tuber-

culosis as a means of exchanging ideas on tuberculosis control in various parts of the world. Another Edmonton man is spending six months at the Montreal Neurological Institute to obtain training as an electroencephalograph technician.

Public Health

To help Winnipeg extend its school dental health program, the federal government has agreed to grant \$3,700. Under the current arrangement the Winnipeg Dental Society provides dentists who carry out clinical dental examinations of school children from kindergarten through grade six. The dentists give their services without charge and examinations are as thorough and complete as can be done outside a dental office. The grant meets the salaries of four assistants who make preliminary arrangements in each school and help the dentists during the clinics. Funds are also used to pay for extra equipment and supplies.

Dieppe House, St. Hilaire, Rouville County, P.Q., has been awarded a federal grant to extend its work among epileptics. The grant covers the salaries of two additional nurses and two full-time occupational therapists. The latter will extend the work already being done in carpentry, cabinetwork, shoemaking, leatherwork, weaving, and similar arts. Amount of this grant in the current fiscal year is more than \$10,500.

To aid the Western Society for Physical Rehabilitation, Vancouver, in training handicapped children, the federal government has allotted \$7,000. The grant will pay for equipment in the new wing of the society's building, particularly for the extension of physiotherapy, hydrotherapy, remedial and speech therapy.

St. Joseph's Hospital, Saint John, N.B., is establishing a new arthritis clinic which will care for patients referred either from the out-patient department or from doctors in any part of the province. It is under the auspices of the Canadian Arthritis and Rheumatism Society. A federal grant of \$9,100 will provide technical equipment such as, ultraviolet

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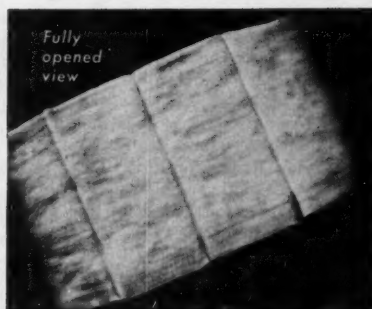
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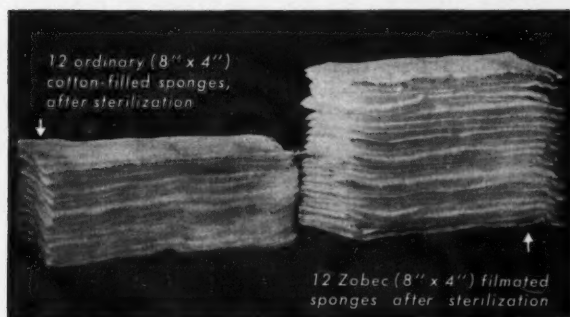
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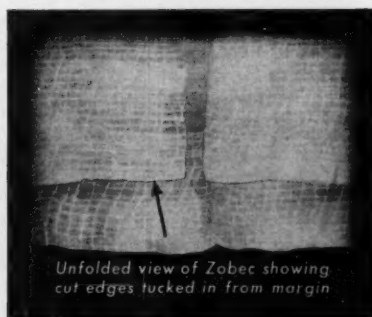
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◀ Provincial Notes ▶

Newfoundland

CORNER BROOK. The new 107-bed Western Memorial Hospital was officially opened at the beginning of January by Premier J. R. Smallwood of Newfoundland. The main section of the hospital is four storeys in height and has a sub-basement housing the boiler plant. One three-storey wing extends from the main structure. The basement includes such facilities as an out-patients' clinic, an emergency operating room, and x-ray department, while the dietary department as well as administration offices are located on the first floor. The maternity section is on the second floor and part of the third floor is used for the paediatrics department. Architects for the hospital were Fetherstonhaugh, Durnford, Bolton, and Chadwick, of Montreal.

SPRINGDALE. It is expected that the new 27-bed health centre which was started last September will be ready for occupancy this spring. It will be a three-storey structure with a full basement and measures 147 by 35 feet, with a wing of 24 by 50 feet. The hospital will serve all the Green Bay area.

Nova Scotia

LUNENBURG. At a recent meeting of the Lunenburg Hospital Society approval was given to a proposal that plans for the hospital, now under construction, be modified and that the main floor together with part of the basement be completed at this time, if funds are available. The modified plans would provide for 35 beds and the total cost would be approximately \$205,000, with government grants providing \$76,000.

SYDNEY. Plans for the proposed

new Cape Breton County Mental Hospital have been redesigned to reduce the use of steel. The hospital, estimated to cost at least \$2,000,000, is being built to provide new and increased patient accommodation as the larger wing of the present hospital was destroyed by fire last year.

TATAMAGOUCHE. The Lilian Fraser Memorial Hospital is seeking approval from the Red Cross, which operates the hospital, and the provincial and federal governments, for an extension to the present building. Plans now call for an extension of some 30 feet to the existing unit to provide nursery space, improved case room facilities, dining room, and a kitchen basement.

Ontario

HAMILTON. The 322-bed "long-stay" hospital to be erected on the Mountain will be named the Henderson Convalescent Hospital in memory of the late Nora Frances Henderson, who contributed much to civic affairs in Hamilton. The building will be of concrete construction with a long wing running north and south and smaller wings jutting south-west and north-west to house the auditorium and administration sections. The main wing will be four storeys in height with a partial fifth floor. Balconies and solariums will be provided on all floors. The first, second, and fourth floors will be used for long-stay patients, while the third will be for short-stay. Heating is to be supplied from the nearby Mount Hamilton Hospital.

LONDON. Construction of a new wing at the Parkwood Hospital for Incurables is scheduled to begin this summer. The addition will provide space for 50 beds and the middle section will have three storeys, the side

sections two. This building of reinforced concrete, with the exterior of red brick and stone facing, will be connected to the main hospital. Patients' rooms are to be located on the first two floors; the third floor will be used for employees' rooms; and the basement will contain therapy rooms. When the addition is completed the capacity of the hospital will be 200 beds. Costs for the new project are estimated at \$465,000 and a provincial grant of \$100,000 has been allotted. The architect is O. Roy Moore.

NORTH BAY. The opening of the new North Bay Civic Hospital has been delayed as funds have not been available to furnish the six-storey, 100-bed structure. Construction costs are estimated at \$850,000 and \$150,000 is needed to furnish the building.

PEMBROKE. The Renfrew County Council recently approved a \$50,000 grant to the Pembroke Cottage Hospital which will help to defray construction costs for a 50-bed addition to the hospital. This addition will double the present capacity. About \$366,000 of the total estimated cost of \$420,000, excluding furniture, will be contributed by government grants.

PORT COLBORNE. The new Port Colborne General Hospital was officially opened last month. This \$1,000,000, 70-bed hospital was built as a memorial to the service men of the district who died in World War II.

RAINY RIVER. The new Rainy River Red Cross Hospital was officially opened at the end of January. This 14-bed hospital was built and equipped at a cost of \$147,000 and replaces the former 9-bed unit. The building is a one-storey, brick frame structure with a basement. Facilities include: two semi-private rooms, three wards, an office, waiting room, a five-crib nursery, delivery, oper-

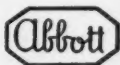
(Continued on page 82)

48 hours

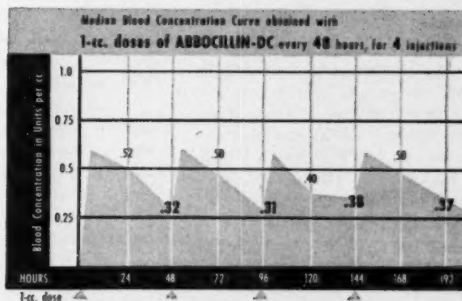
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With the Auxiliaries

Maritime Auxiliaries to Help Civil Defence Committee

In response to an appeal from the Provincial Civil Defence Committee, the Maritime Hospital Aid Association has undertaken a plan of service. The Association, in co-operation with the Maritime Hospital Association, has asked the hospital auxiliaries to form and sponsor first aid classes, and to carry out any survey or surveys thought necessary by either the Provincial Defence Committee or a local committee.

Present plans call for 1,000 women to be trained through the auxiliary-sponsored, St. John Ambulance Course, which is open to non-members as well as members. The course consists of six lectures of two hours; one hour being used for theory and the other for demonstration and practice. The instructor may be a doctor or a certified instructor of St. John Ambulance and examinations are given by one other than the instructor. Upon completion of this course, the Association may organize a home nursing course, also under St. John Ambulance.

In a letter issued to the executives of the auxiliaries, Gladys M. Porter, hospital representative, Maritime Provincial Defence Committee, summed up the need for preparedness in her statement, "without wishing to cause anxiety—please stress the urgency of preparedness (while praying that there be no crisis and firmly believing that God, our Ancient Ally, is still on our side)".

* * * *

Successful "January Nite" Held by Women's College Hospital Aid

The Ladies' Aid to the Women's College Hospital at Toronto, Ont., recently held its annual "January Nite". This event has become the big money-raising venture of the auxiliary. The net proceeds this year were approximately \$3,500. For the past three years the major part of the proceeds from this dance have

been used to finance a \$1,500 fellowship in pathology. The current recipient is Dr. Dorothy C. Ley, a graduate in medicine from the University of Toronto in 1948. This year, as well as continuing the fellowship, the auxiliary plans to use the money to purchase a new blood bank and a basal metabolism machine.

"January Nite" was organized 18 years ago to raise money for the hospital and it was three years later, in 1936, that the hospital aid was formed. The Cradle Club, another auxiliary which looks after the needs of the obstetrical department, held its annual hope chest draw as part of the many events of the evening.

During the past year the auxiliary has purchased a new suction machine for the operating room, a potato peeler for the kitchen, a refrigerator for the nurses' cafeteria, corsages for the graduating class, and prizes for the intermediate and junior years. A travelling tuck shop for bed-side shopping and a foyer shop are other projects of this active group. A spring tea, bridges, sale of work, the tuck shop, and the sale of hospital calendars also add to the auxiliary's finances.

At a recent annual meeting, Mrs. T. J. Lytle, president of the Ontario Hospital Aids Association, retired from her post as president of the Women's College Hospital Aid which she has held for the past seven years. Mrs. Lytle was presented with an orchid corsage and will be awarded a life membership.

* * * *

Auxiliary Operates Canteens at Vancouver General Hospital

During 1950, some 56,780 patients at the Vancouver General Hospital, Vancouver, B.C., were served hot soup or milk by 24 volunteers of the Women's Auxiliary who work regularly each week in their canteens. The annual report recorded the activities of other committees and showed that these also had excellent records of service. A total of 3,120 trips in 253 driving days were made

by driving volunteers. The social service committee spent a total of \$4,156 for "compassionate" and possible rehabilitation cases.

The maternity sewing committee received 1,030 articles and from this number 881 were given to 49 patients. Over 6,000 calls were made during the year by the visiting committee who visit the Heather Street annex every week and all wards on alternate weeks. This committee also made 51 visits to the Glen and Grandview hospitals and distributed 150 Christmas cheer parcels to the patients. The two-year-old mobile shop proved its worth and assets amounted to \$2,389, with total sales of \$11,505. In addition, the auxiliary aided the nurses' training school by providing \$1,000 for the library, \$1,425 for activities of the student nurses, \$300 to pay the salary of a part-time librarian, and helped provide bedding for the summer holiday cottage.

A Christmas party was held at the Children's Health Centre, by Junior League volunteers, at which some 300 children and adults were entertained. In the out-patients' department 155 volunteers work part-time every week. The finance committee reported that this auxiliary of some 375 members had an income of over \$4,700 and a balance of \$296 in the general fund.

* * * *

Encouraging Reports Given by Grace Hospital Aid, Winnipeg

At a recent meeting of the Ladies' Auxiliary of the Grace Hospital, Winnipeg, Man., the annual reports were read. These reports covered a 20-month period as the fiscal year was changed to end on December 31. Total receipts for this period were \$1,468, with disbursements of \$1,290. Money was raised by teas, a bazaar, and rummage sale. The big undertaking during this period was the raising of \$989 to buy a milk formula sterilizer for the hospital. The auxiliary also assisted at the nurses' graduation, marked linens for the hospital, provided flowers for the mothers in the homese department, and contributed gifts to the girls' home and the babies. Members made many visits and also placed a guest book in the auxiliary ward. Contributions were made to the Red

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This is one in a series of advertisements linking the name Fisher & Burge with those of internationally known firms which they are honored to represent, in Winnipeg, Edmonton, Vancouver and now at 81 Grenville Street, Toronto.

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Cross Society by a donation of \$10 as well as the collection of soap. This auxiliary has an approximate membership of 70.

* * * *

Aid Supplies Gifts to Hospitals at Saint John, N.B.

The Women's Hospital Aid to the Saint John General and Tuberculosis Hospitals at Saint John, N.B., distributed many gifts to the hospitals at Christmas. Approximately 200 patients received presents at the General Hospital and the auxiliary supplied Christmas trees for decorations. The nurses also were given a record player and radio at a Christmas party and the new class of probationers were entertained at a party early this month. In addition to these, gifts were presented to the patients at the Saint John Tuberculosis Hospital. The treasurer's report, given at a recent meeting, showed expenditures of \$394.46 with balances of \$128.92 in the general fund, \$36.68 in the flower fund, \$330.28 in the Emma Elizabeth Noble convalescent fund, and \$189.88 in the emergency fund.

* * * *

Auxiliary Helps Purchase X-Ray Equipment

The women's auxiliary to the Soldiers' Memorial Hospital at Tillsonburg, Ont., recently voted \$5,000 to the hospital board as partial payment for the x-ray equipment for the new hospital. The balance of the cost will be paid by the auxiliary at the earliest possible date. A bake sale was held last month and plans are under way to hold a large card party this spring. At this function the winners of the two marathon bridge series, which the auxiliary has sponsored, will be announced.

* * * *

Busy Days for Hospital Aid at Carman, Manitoba

Last year was filled with many busy days for the ladies' aid to the Carman Memorial Hospital, Carman, Man. Their many activities included visiting patients, purchasing and making-up material required by the hospital, mending, and canning more than 1,000 quarts of fruit and vegetables. The ladies also sponsored a

tag day and shower as one of the main money-raising ventures of the year.

* * * *

Showers Prove Valuable Way to Supply Needs of Hospital

The Women's Auxiliary to the St. Marys Memorial Hospital at St. Marys, Ont., have supplied their hospital with many needed items by holding showers. At a recent shower 40 vases and eight baskets were received and donated for use in the hospital wards. Members are also contributing cups and saucers. These projects, however, do not complete the auxiliary's work. Recently, it was decided to donate \$700 to the hospital, \$400 of which is to be used for linens, with the remainder to cover certain expenses at the nurses' home.

A booth for knitted goods and babies' wear is maintained in the hospital by the auxiliary and is supplied by donations of hand-made articles. The farm women's group of the auxiliary has undertaken to supply the hospital with wastepaper baskets while future plans of the whole group include the purchase of a cupboard for dishes, a container for books and magazines, and stamped envelopes for patients' use.

* * * *

Linen Main Work of Auxiliary at Williams Lake, B.C.

The main work of the Women's Auxiliary to the War Memorial Hospital at Williams Lake, B.C., is supplying and repairing the linen. The members do the mending and make nearly all the new articles. An annual "telephone crib and bridge tournament", a fashion show assisted by local stores, and a pound tea, enabled the auxiliary to purchase a new electric sewing machine, four metal enamelled bedside tables, two adjustable over-bed tables, an electric tea kettle, and an electric heater for the nurses.

* * * *

Auxiliary at Carmangay, Alta., Reviews Year's Work

A review of last year's work by the Ladies' Auxiliary to the Little Bow Municipal Hospital at Carmangay, Alta., showed that many dona-

tions had been made to the hospital. A hot-plate and dishes were purchased for the nurses' home, along with a number of smaller items. In addition to this, sheets, pneumonia jackets, hospital gowns, and numerous other articles were bought for the hospital.

* * * *

Gifts for Hospital

A set of English porcelain dishes for use in the Hotel Dieu Hospital at Edmundston, N.B., was donated by the Hospital Aid Society. This group also provided all the children in the paediatrics department with gifts at Christmas and these included electric trains and dolls for the older children.

* * * *

New Project Undertaken by Grace Hospital Auxiliary, Ottawa

A new project was undertaken by the Ladies' Auxiliary to the Grace Hospital at Ottawa, Ont., when a recent vote allotted money for the purchase of an examining table for the out-patients department. Annual reports given by officers and convenors of the auxiliary showed that the members' work during the past year had been active and successful.

* * * *

Year-Old Auxiliary Shows Excellent Results

After a year of operation the Ladies' Auxiliary to the Oakville-Trafalgar Memorial Hospital at Oakville, Ont., ended the year with a balance of \$638.54. The amount of \$3,406.37 was raised and \$2,767.83 was expended during the year. Activities of the auxiliary include sewing, work in the cutting room, arranging flowers, running the tuck shop, library, and information desk.

I.H.F. Announces Reorganization of German Hospital Association

In a recent communication Capt. J. E. Stone, honorary secretary and treasurer of the International Hospital Federation announced that the German Hospital Association was recently reorganized and is now in operation. Although hampered by lack of finances the Association is making good progress.

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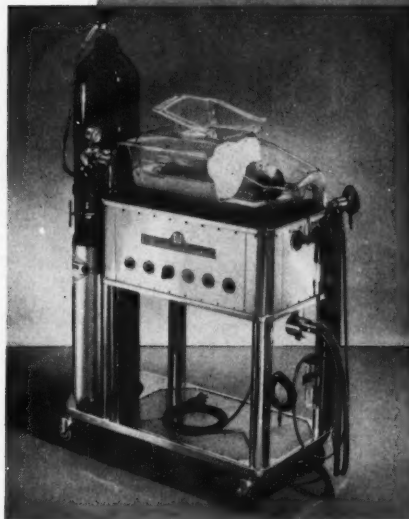
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IVR "LARGE TANK" MODEL

These two models have for years been the standard equipment of progressive hospitals throughout the world, contributing materially and often spectacularly to each hospital's never-ending fight to drive ever lower the ratio of patient deaths. Both models have the same operating mechanism and Controls. Both are accepted by the Council on Physical Medicine and Rehabilitation of the American Medical Association. For complete information request Bulletin R503-2.

The RESUSCINETTE for the newborn



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The Resuscinette has been developed by E&J engineers in co-operation with obstetricians to provide, for the first time and in one compact unit, every facility needed for the logical sequence of treatment of the newborn!

NOTE THESE FEATURES

- 1 TRANSPARENT CRIB WITH 3-SECTION COVER to receive the infant and hold in proper position for treatment.
- 2 AUTOMATICALLY CONTROLLED WARM, MOIST ATMOSPHERE within the crib to avoid shock of usual room temperature and humidity.
- 3 FULLY ADJUSTABLE HEAD SUPPORT, normally lowered, raised for cerebral hemorrhage cases.
- 4 BUILT-IN E & J ASPIRATOR at finger-tips for immediate clearance of air passages.
- 5 BUILT-IN E & J POSITIVE-NEGATIVE RESUSCITATOR with safe, gentle, fully controlled respiratory rate for resuscitation by either mask or intratracheal techniques, automatic signal if air passages are blocked and automatic signal when natural breathing starts.
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- 9 USE AS REGULAR RESUSCITATOR-ASPIRATOR for routine treatment of any person, infant or adult.

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Elastoplast

TRADE MARK

A BATTLE Casualty with considerable destruction of the palm of the hand, the little finger and the fifth metacarpal joint. Skin grafting was carried out as a preliminary measure to produce a healed surface. Later there was excision of graft and scar tissue with application of a direct flap from the back. Fixation was secured with Elastoplast prior to division of the base of the flap.

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Fig. 1. Condition on admission.



Fig. 2. After excision of graft and scar tissue. Application of direct flap from the back. Note fixation.



Fig. 3. Flap in position. Full extension of fingers.

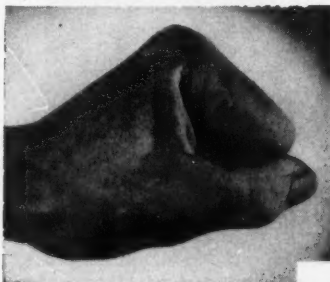


Fig. 4. Formation of fist.

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PETROLAGAR WITH MILK OF MAGNESIA
PETROLAGAR WITH CASCARA



Lengthening Life Span

(Continued from page 42)

- (b) Specific facilities for the care of the senile and aged who require some nursing care and supervision.
- (c) Adequate accommodation for well old people without homes or support (residential homes, homes for the aged, and the like).
- (d) The integration of homes for the chronic sick with a general hospital to ensure adequate follow-up.
- (e) The development of departments of Geriatrics in the larger hospital centres where every modern facility for diagnosis and treatment can be provided for both in- and out-patients.

It is generally agreed that wherever possible, the elderly and chronic sick should be retained in or returned to their own homes, provided there is sufficient help for their comfort and welfare, and the home conditions are suitable. Many elderly and chronic sick still have to remain in a hospital or a home and such cases must be carefully classified so that they may be best diagnosed, treated, and finally housed. It is considered that investigation should be undertaken, diagnosis made, and treatment undertaken in specially equipped units of a general hospital set up for that purpose (Geriatrics units).

Geriatrics Departments

Geriatrics is the science and art of medical service to the ageing and the aged. It is concerned with the prevention of chronic disease and degenerative ailments and with the extension of vigour among the ageing. It is argued that the provision of Geriatrics units in general hospitals with all modern facilities and staff for investigation, diagnosis, and treatment, would raise the standard of work done, shorten the time of stay in hospital, and avoid the necessary blocking of beds by patients who could be treated sufficiently if they returned to their own homes or entered a home^{21, 25}.

Cosin has said "improved care of the aged sick depends upon the organization of a Geriatrics department in the hospital system," and "a change in attitude toward these patients from that of resignation to the inevitability of endless months in bed, to active investigation, ensuring that each patient has the

optimum chance of enjoying even limited activity and independence".²⁶

Rehabilitation

The object of geriatric rehabilitation is to restore the maximum degree of personal independence by remedial exercises. This calls for treatment by a team including medical and nursing staff, physiotherapists, occupational therapists, medico-social workers. Mental stimulation, exercise, and physical aid, all play a vital part.

Rehabilitation is necessary if a large proportion of the older individuals are to find their added years both productive and enjoyable and at the same time not throw a burden on the younger and middle-age groups. Recreation and participation are important aids in decreasing hospitalization and the need for medical and nursing care.

Medical Education and Research

The general feeling among medical educators is that integration of teaching in the various departments, medicine, surgery, psychiatry, et cetera, will bring about a more thorough understanding of the medical problems of ageing than any attempts to teach geriatrics as a separate sub-division of medical teaching.

There seems to be much, however, to recommend geriatrics as a specialty. This branch of medicine is an important subject for medical students and should form a specific part of their curriculum.

Greater emphasis on research into the diseases which accompany advancing age and into the process of ageing (gerontology) must be encouraged and undertaken. This includes the fields of biology, physiology, psychology and sociology. Fruitful research on the problems of old age, chronic illness, and premature ageing, will not only render old age more efficient and comfortable but will decrease the future tax burden for care of the chronically ill by reducing the number requiring care and decreasing the time that care is required.

Discussion

Since the elderly suffer twice as much from sickness as those of working ages, more and more of the work of the general practitioner will

be concerned with the care and treatment of old people. Likewise in the hospital sphere, there will be a great and increasing demand for facilities for the care of the aged and the chronic sick.

There are three medical aspects of importance:

(a) The first problem is the training of the general practitioners and nurses upon whose care in the home a great part of the problem must continue to rest.

(b) The second problem is the procurement of adequate hospital beds of proper type and the proper integration of these beds into a co-ordinated service. With the great pressure on hospital beds for acute cases, fewer are available for the elderly or chronic patient, many of whom remain at home or in stagnant rest homes with inadequate facilities and inadequate nursing care.

(c) The third problem is that of discharging patients from hospital.

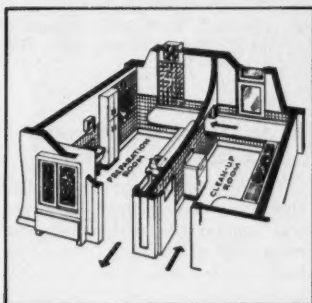
Until sufficient geriatrics units are established, it is probably best for the aged and chronic sick to pass through the wards of a general hospital for investigation and assessment. Every attempt must be made to prevent such cases from becoming stagnant and blocking beds which should serve the acutely ill.

Cosin has said: "Get them up, keep them interested, and send them out, is the attitude which is essential to prevent blockage of beds. If adequate accommodation were available for those who were ambulant, sitting up of hospital wards might never occur. If there were adequate outpatient clinics, many admissions could be prevented. If there were plenty of trained personnel available, thousands of bedridden patients could be made active and self-supporting within a year or two"²⁷. Howell has said: "We must shift the focus of attack to the home, the outpatient clinic and the hostel. To wait until the patient has been admitted to hospital, too often means that the time for treatment has passed and gone"²⁸.

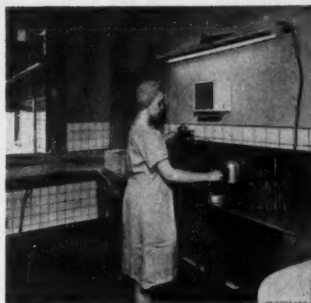
Comments

1. The diseases and conditions which attack middle aged and elderly people are our major health

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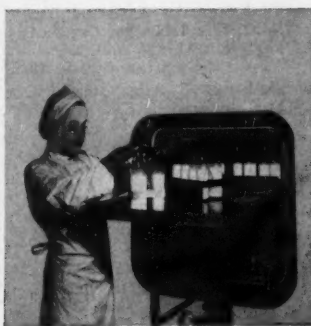
Washing room. Only clean technique must be observed here since bottle, nipple and cap will be subject to terminal heating as final step.



Formula room. The entire product—formula, bottle, nipple and nipple cap are placed in the autoclave for terminal heating at 230°F. for 10 minutes.



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problems today. The awakened public interest in the problems of ageing and old age is a manifestation of the public consciousness of the need!

2. Physiological age is not synonymous with chronological age. A man's usefulness does not necessarily begin to diminish at age 45, nor terminate at age 65. Recognition of this fact is of great significance not only to the employers but to the medical and nursing professions and to all community health and social workers.

3. The medical and the public health aspects of the problems of an ageing population cannot be more than sketched here. The problem is one of increasing importance; it calls for planned action and conscious interest by medical and by public health authorities.

4. The changes which have taken place in the demographic picture require suitable adjustments in the public health and medical care programs. More and more activities must be concentrated on the diseases and conditions which affect the older age groups. Medical science and public health administration must adapt their services and facilities to meet the health needs of the middle aged and older people.

5. It is imperative that we give due consideration to all practical measures which can be applied to the maintenance of the health of the ageing, and to the postponement of the day when they will require a great deal of assistance, and eventually full bed-care. Where there has been deterioration in health or sickness or injury, the problem becomes one of rehabilitation.

6. The future calls for:

- (a) A drive on those diseases which are specifically associated with older age.
- (b) Increasing emphasis on medical research in the degenerative diseases and the problems of old age.
- (c) Provision of much needed hospital, home, and rehabilitation facilities for the chronic sick and aged.
- (d) Attempts to meet the demands for more medical and nursing care which are inescapable.

The objective of the combined efforts of all those concerned with the health and welfare of our people must be, to quote Dr. L. Z. Cosin,

Medical Superintendent of the Orsett Lodge Hospital, Essex, England, to "Seek to add not years to life, but life to years", so that it will not again be possible for an elderly patient to say, "You don't really live longer, it only seems longer".

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Air Ambulance Celebrates Fifth Year of Service

The fifth anniversary of the Saskatchewan Air Ambulance Service was celebrated last month. Its record of no accidents where injuries of any kind have been sustained remains intact. Since operations were commenced on February 3, 1946, approximately 4,000 individual patient flights have been completed and a total of nearly two million miles have been flown. The average round trip flight is approximately 300 miles.

Since the beginning of the new year the Service has added two new pilots; and one new plane, a Cessna 195, is the third of this type to be acquired. Originally, the Air Ambulance Service consisted of a used Mark IV Norseman, one pilot, one registered nurse, and one qualified air engineer. Today it operates four aircraft, including three Cessna 195's and one twin-engine Beechcraft. The total staff is now 17, including four pilots, three flight nurses, four engineers, three mechanics, one radio technician, one stenographer, and one caretaker.

According to reports the air ambulances are never further than one hour and thirty minutes flying time from any point which is considered to be a populated area. Bases in Regina and Saskatchewan provide transportation for the sick in an area of about a quarter of a million square miles, while a similar service is offered in northern areas by Saskatchewan Government Airways.

The activities of the Air Ambulance are not limited to the winter season alone; mileage from month to month throughout the year varies by only about five per cent.

A sharp tongue is the only edge tool that grows keener with constant use.—*Washington Irving*.

A Salute to the HOSPITAL for SICK CHILDREN

on the occasion of the opening
of this superbly planned and
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We deem it a privilege, indeed,
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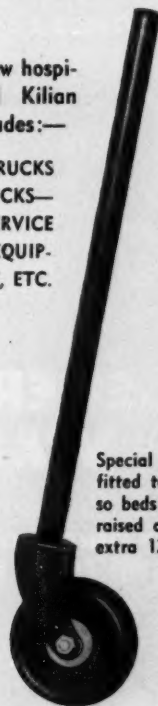
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fitted to casters
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extra 12 inches.



New Institute of Radiotherapy To be Established in Toronto

As a strong weapon in the fight against cancer, a modern, well-equipped Institute of Radiotherapy will be established in Toronto, Ontario. According to provincial Premier Leslie Frost, the institute "will be so constituted, designed, and located, as to provide every known facility and device for diagnosis and treatment of cancer, and for research into the problem of cancer and its prevention and cure". The building is to be constructed on property adjoining the Wellesley unit of the Toronto General Hospital.

Equipment for the centre will be of the most modern type, including the latest super voltage x-ray therapy machines and a radioactive cobalt bomb. It will also include facilities and equipment for isotope therapy, as well as standard radiotherapeutic equipment. Adequate space will be provided for experimental research. The building will also contain the necessary adminis-

tration offices, a suitable number of examining rooms, lecture and instruction rooms, out-patient clinics for follow-up examinations, laboratories, and such other space and facilities as may be required.

Direction of the institute will be undertaken by the Ontario Cancer Treatment and Research Foundation, but the management and treatment will be under the medical staff of the Toronto General Hospital in conjunction with the medical faculty of the University of Toronto. Medical specialists from other Toronto hospitals will also be included on the staff.

A special design is required for the building to withstand the weight of heavy equipment and to protect the staff and patients from the effects of the radioactive isotopes. The structure alone will cost approximately \$2,000,000; while the total cost is likely to be around \$6,000,000. The Ontario Cancer Treatment and Research Founda-

tion will contribute \$400,000 and the remainder will be raised by government grants with the federal government contributing dollar-for-dollar to the provincial allotment. The institute will be the hub of a network of cancer centres in the province. It will also provide facilities for the training of radiotherapists who formerly had to receive training outside the country.

Canadian Influenza Centre Established in Ottawa

A Canadian influenza centre has recently been established at the federal health department's laboratory of hygiene in Ottawa. It will co-operate closely with similar setups in the United States and the United Kingdom in studying the type and method of spread of the influenza virus in any part of Canada. The centre will be a clearing house for information on influenza for provincial laboratories, university medical schools, and health departments. It will also function as the Canadian division of the World Health Organization's influenza information service.

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Extension Course for Medical Record Librarians

The School for Medical Record Librarians at St. Michael's Hospital, Toronto, Ont., has undertaken a program of in-service training for medical record department personnel, which will be held at that hospital from May 14-18. Anyone presently or previously employed in a medical record department will be eligible to attend this course. Each will be required to pay fees of \$5.00 on application and \$20.00 for enrolment. Applicants are asked to secure a copy of the *Standard Nomenclature of Disease and Operations* and arrange for their own accommodation.

Three topics are scheduled for inclusion in the extension course. One topic, Medical Record Library Science will include a discussion of such subjects as the ideals and responsibilities of a medical record librarian, evolution and contents of medical records, and their use. Lecture courses in Medical Terminology and on the *Standard Nomenclature of Disease and Operations*

will complete the course.

Approved schools for medical record librarians in Canada are located at the Hotel Dieu, Kingston, Ont., St. Michael's Hospital, Toronto, Ont., and the Hotel Dieu Hospital, Montreal, P.Q. Schools now approved for opening will be at St. Boniface Hospital, St. Boniface, Man., the Halifax Infirmary, Halifax, N.S., and St. Joseph's Hospital, Peterborough, Ont.

Campaign for Healthful Eating

Ontario's public health authorities are developing an extensive program to spread the principles of healthful eating. The current campaign concentrates on three groups — children, expectant mothers, and older persons. Long-term studies indicate that a considerable number of children are not receiving adequate supplies of milk, and vitamins C and D, all of which are essential to growth and good health.

From the beginning, the educational program will attempt to

arouse a greater interest in good nutrition among professional people responsible for public education on health matters — doctors, dentists, public health and welfare workers, school teachers, home economists, et cetera. Every effort will be made to keep them informed of the newest developments and to fill gaps in present knowledge.

The entire program is being keyed to "Canada's Food Rules" as approved by the Canadian Council on Nutrition and will result in a greater uniformity in the nutritional education activities of the provincial departments of agriculture, education, welfare and health. A grant of \$10,400 from national health funds will finance the program.

Tax Defaulters Fined

During 1950, 179 persons were prosecuted under the Saskatchewan Hospitalization Act for non-payment of the hospitalization tax, compared to 134 the previous year, according to G. W. Myers, executive director of the SHSP.—*Saskatchewan News Bulletin*.

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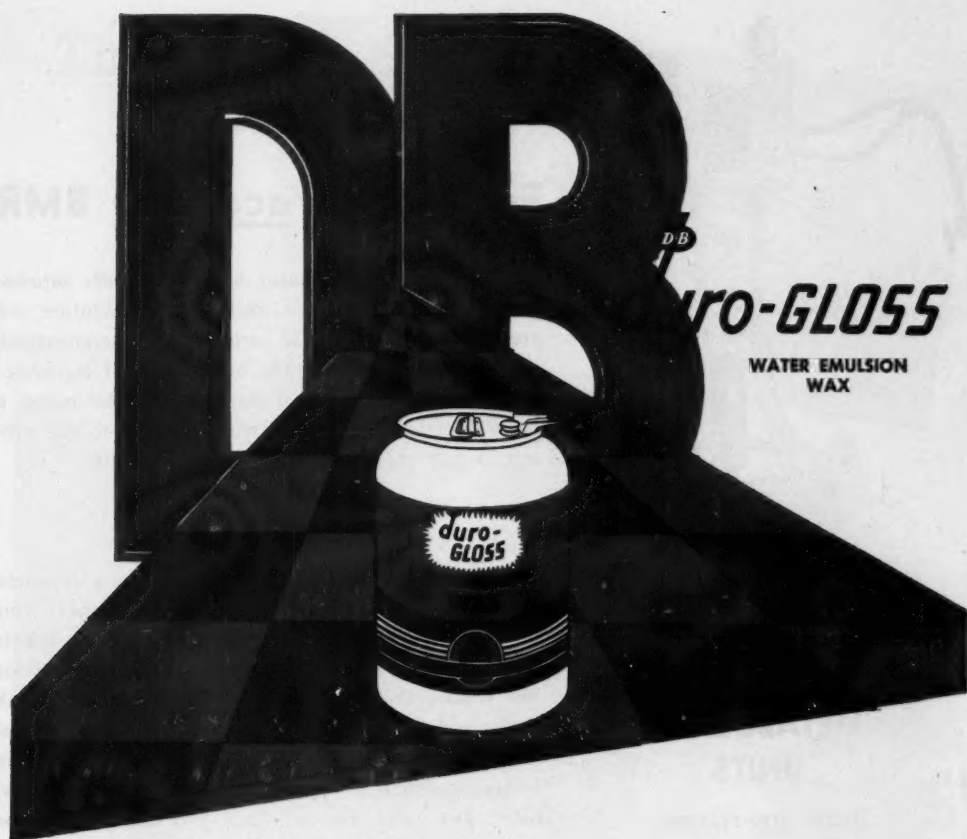
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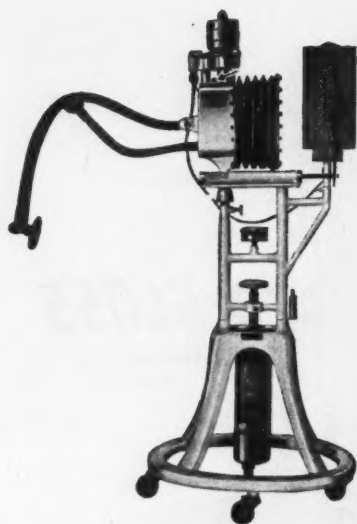
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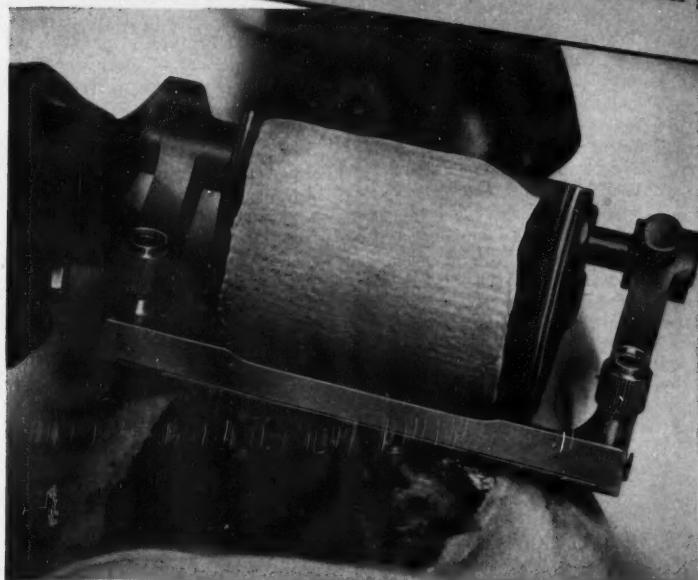
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First Civil Defence School Held in Saskatchewan

Saskatchewan's first civil defence school was held in January at Fort Qu'Appelle, with 18 students enrolled for the one-week course. Students attending the course came from 14 centres in the province and most were representatives of their home municipalities.

The week-long course included lectures on such subjects as civil defence organization on the federal, provincial, and municipal levels; nuclear physics and atomic warfare; defensive action against high-explosive and other types of bombing; and fire-fighting methods as applied to civil defence.

In addition, a number of films, slides, and practical demonstrations were presented relating to the various aspects of these subjects. A written examination completed the course and representatives returned to their communities with valuable information for their local organizations.

Further civil defence courses are planned for the near future. The main purpose of these schools is

to provide a basis for a well-organized program by supplying integrated information on all phases of civil defence. The initial course was given under the general direction of Lt. Col. J. R. Mather of Regina, provisional civil defence officer for the province.

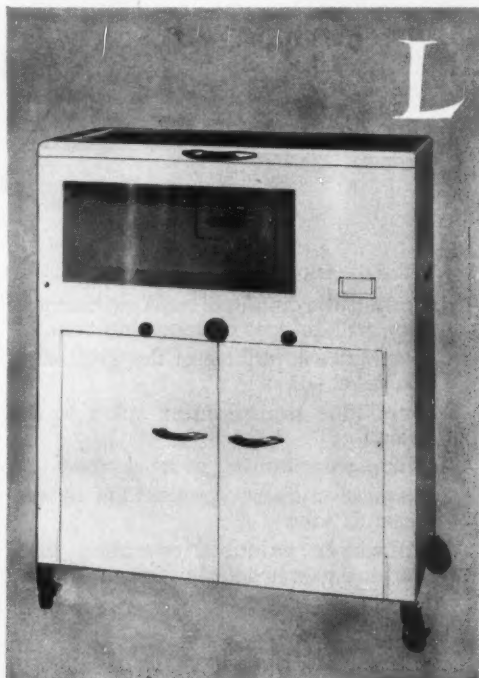
WHO Honours Three Scientists

Three scientists were honoured recently by the World Health Organization. Two Britons, Professor H. T. Shortt and Dr. P. C. C. Garnham, were awarded the Darling Foundation Prize for their joint work on the life cycle of the malaria parasite in man and monkey; and Professor Rene Sand, president of the International Hospital Federation, was nominated for the Leon Bernard Foundation Prize for achievement in social medicine.

The Darling Foundation Prize consists of a bronze medal and 1,000 Swiss francs. It was set up by the League of Nations to honour the famous malariologist, S. T. Darling, and was last awarded in

1938. One of the recipients, Professor Shortt, occupies the chair of Medical Protozoology at London University and is president of the Royal Society of Tropical Medicine and Hygiene. He is well known for studies in malaria and kalaazar. Dr. Garnham, the other recipient, is a reader in medical parasitology at London University. He spent many years in Africa, where he became widely known for studies in tropical medicine, epidemiology, and malaria.

The Leon Bernard Foundation Prize was established by international subscription in perpetuation of the memory of Professor Leon Bernard of France, a member of the League of Nations Health Committee. The prize consists of a medal plus 1,000 Swiss francs and was last awarded in 1939. Professor Rene Sand, the recipient, holds the chair of Social Medicine at Brussels University, Belgium. He has spent a lifetime promoting the philosophy and practice of social medicine and is the author of several authoritative books on the subject.



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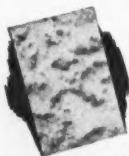
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Red Cross Society

(Concluded from page 37)

develop in them a sense of social responsibility by giving them opportunities for community service. It also fosters international understanding through school correspondence and emergency relief. With the administrative costs of this program borne entirely by the senior society, all funds raised by Juniors are used to assist handicapped and crippled children in this country and to provide food, clothing, and medical supplies to children in war-devastated countries abroad. Crippled children's hospitals are operated in Regina and Calgary while the Juniors also finance the treatment of needy handicapped children in other provinces.

One of the basic responsibilities of the Canadian Red Cross Society, as specified in its by-laws, is to organize and maintain an emergency service to render immediate assistance to disaster sufferers. For many years Canada was singularly free from disaster but during 1950 Red Cross rendered aid in over 500 emergencies, three of which were

major disasters—the Red River flood, the Rimouski and Cabano fires. As a general policy in disaster, Red Cross concentrates on providing food, clothing, shelter, and medical aid during the emergency period not usually covered by any other agency, either governmental or private. The heavy financial responsibility assumed in disaster is one of the major reasons for the independent and flexible fund-raising policy of Red Cross, as disaster not infrequently requires the expenditure of funds in a community far beyond the capacity of that community to raise over a long period. For example, over a half a million dollars was spent in the Winnipeg area within six weeks, while the whole of Manitoba—a province most generous in proportion to its population—had contributed only \$392,681 for the year toward the support of all Red Cross work, local, national, and international.

In a brief article, such as this, it is impossible to portray all the services of Red Cross. For that reason, no mention has been made of instruction in First Aid, particularly

to nurses; swimming and water safety which includes teaching the physically-handicapped to swim; the homemaker's service maintained in some provinces; the dental coaches of Ontario and Quebec; the mother's milk service of Saskatchewan; the soldiers' clubs of Toronto and London, port nurseries for immigrants; Newfoundland's hostel; emergency relief to needy veterans; and countless other more or less local projects.

While the Canadian Red Cross Society is a national, voluntary, organization with headquarters in Toronto, it has divisional offices in each of our ten provinces supervising the work of nearly 1,400 senior branches with approximately 1,172,000 voluntary workers, and over 900,000 junior affiliates.

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TORONTO 13

The Shriners' Hospital

(Concluded from page 35)

ing on a huge butterfly perched at the end of his tail, or a duckling in a little red canoe with a mauve paddle. The babies are not forgotten either. The very little boys have such delightful things as two brown spaniels asleep on a quarter moon as decoration for their wards, while on the walls of the baby girls' rooms two little cherubs are pictured climbing up a cloud of stairs to bed,

with red candles in their hands, and rather reluctant expressions on their faces.

In the basement playroom, the lower part of the walls are of varicoloured cobble-stones. Above this, murals feature playful animals and scenes familiar to children. Here, one can see a baseball game in progress and there, little boys dive gaily into the old swimming hole. Natural features of the room are utilized, with one mural depicting a boy holding up a window, while an-

other shows youngsters climbing over a door.

The entrance to the out-patients' department has a most appropriate decorative theme. Forming an arc around the door, a mural pictures small children who leave wheelchairs behind to climb to the treetops of health and happiness. A Shriner symbol at the very top shows a small boy carrying his crutch. This entrance is aptly called, "The Door of Optimism", and helps to encourage parents and children entering the hospital for the first time.

Decoration brightens the school-room, too. In this special unit located on the main floor, walls have murals depicting children of different nationalities in colourful native dress. Blackboards are green and desks are built in three sizes.

All murals were painted by a group of three to five artists, under the direction of Don Howard, of the T. Eaton Company, who was in charge of decorations. About thirty different colours were used in the murals which are washable.

Every convenience for young patients has been installed throughout the hospital. There are special reading lamps and special beds for treating fractures. All rooms and wards are air conditioned and soundproof.

Most certainly this lovely new hospital is a tangible expression of the generosity of Shriners and of all those who contributed in any way. Poet Laureate, John Masefield, paid tribute to their achievement in a poem which now occupies a place of honour in the hospital entrance.

Nor is the treatment provided by this hospital complete when young patients are ready to leave. A special supply room filled with little dresses, suits, and overalls, provided by the Ladies' Auxiliary, is very much a part of the endeavour to send away not only healthy but also happy children. And if any child should need further aid, he can always turn to his "big brother"—a Shriner who will continue aid as long as it is needed.

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Canadian Red Cross Society to Stockpile Blood for Defence

According to an announcement from the Department of National Defence, the Red Cross Society has been appointed official agency for securing, processing, and supplying blood and blood products for the Canadian armed forces, at home and abroad, and for civil defence purposes. This major commitment which the Society has undertaken at the request of the government, will necessitate not only increased financial support but the enrolment of vast numbers of additional blood donors in order that civilian hospitals in Canada, as well as the armed forces, may have adequate supplies.

Civilian and veteran hospitals presently served by the Red Cross free Blood Transfusion Service are using approximately 210,000 bottles of whole blood annually. It is estimated that the immediate needs of the Department of National Defence, including initial steps in civil defence preparedness, will require a further 100,000 bottles of blood during 1951.

Coming Conventions

- March 26-27—Sectional Meeting of the American College of Surgeons, Hotel Multnomah, Portland, Ore.
- March 29-30—A.H.A. Institute on Dietary Department Management, Hotel Kenmore, Boston, Mass.
- Apr. 16-18—Annual Conference of Blue Cross and Blue Shield Plans, Buena Vista Hotel, Biloxi, Miss.
- May 3-4—A.H.A. Institute on Laundries, Palmer Hotel, Chicago, Ill.
- May 7 (week)—Second Ontario Institute, Queen's University, Kingston.
- May 9-11—Sectional Meeting of the American College of Surgeons, Book-Cadillac Hotel, Detroit, Mich.
- May 28-30—Biennial Meeting of the Canadian Hospital Council, Ottawa.
- June 2-5—Catholic Hospital Association of United States and Canada, Convention Hall, Philadelphia, Penn.
- June 4—Maritime Hospital Association, Algonquin Hotel, St. Andrews-by-the-Sea, N.B.
- June 18-22—Canadian Medical Association, Mount Royal Hotel, Montreal.
- June 18 (week)—Western Canada Institute for Administrators and Trustees, University of Alberta, Edmonton.
- June 25-27—Congrès des Hôpitaux Catholique du Québec.
- July 15-21—Second Postwar Congress of the International Hospital Federation, Brussels, Belgium.
- Sept. 12-15—Canadian Society of Radiological Technicians, Royal Alexandra Hotel, Winnipeg.
- Sept. 17-20—American Hospital Association, St. Louis, Mo.
- Oct. 11-12—Saskatchewan Hospital Association, Hotel Saskatchewan, Regina.
- Oct. 16-19—British Columbia Hospitals' Association, Hotel Vancouver, Vancouver.
- Oct. 24-26—Associated Hospitals of Manitoba, Winnipeg.
- Oct. 29-31—Ontario Hospital Association, Royal York Hotel, Toronto.

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16-9-50

Provincial Notes

(Continued from page 54)

ating, and x-ray rooms, a sterilizing and supply room, a 2-bed children's ward, and a doctor's room. The nurses' residence is located behind the hospital and contains five bedrooms, a living room, kitchen, and bath.

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Applications are available at Post Offices, National Employment Service Offices and the above-named offices.

WINDSOR. Preliminary construction work is scheduled to begin immediately on a two-wing, six-storey addition to the Hotel Dieu Hospital. The capacity of the present 250-bed institution will be increased by 191 beds and 65 infant cubicles. One wing will extend south from the present building; the other will extend east from the same building. The addition is expected to cost around \$750,000 and federal and provincial grants as well as grants from the city will help finance the project.

* * * *

TORONTO. Extensive building activity is under way at St. Michael's Hospital. A new nurses' residence is under construction, an extension to the Shuter Street wing planned, and the new Queen Street unit has recently been opened. The new residence for student nurses will be a seven-storey structure and will contain 98 private rooms. Housed in the new five-storey Shuter Street extension will be five additional operating theatres, a psychiatric unit, utility rooms, and supervisors' rooms. The

new seven-storey Queen Street unit brings the hospital bed capacity to 875.

Manitoba

NORWAY HOUSE. Construction of a new \$1,000,000 Indian Health Services Hospital is scheduled to start this year, and to be completed in 1952. Building material will be shipped by boat from Winnipeg. The hospital, to serve the eastern section of northern Manitoba, is part of a scheme for extended medical service for the Indians of the district. To date, five out-post nursing stations have been constructed or set up.

Saskatchewan

SASKATOON. According to present plans construction on the new University Hospital will proceed as scheduled. Work on the hospital, originally expected to cost around \$7,000,000, was halted two years ago through lack of funds, but recommenced later with plans to complete the building wing by wing as funds



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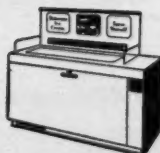
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became available. The project is now estimated to cost approximately \$10,000,000. Concrete for the whole basement has been poured and wing G, to contain the cancer clinic and Red Cross blood bank, has been closed in and interior work is under way. A start has also been made on

two other wings and it is hoped that construction will begin on four more and the centre section, which connects all the wings, shortly. D.V.A. patients will be provided with 100 beds in one of the front wings. Tentative plans also call for construction of a nurse's home on a site west of the hospital.

Alberta

CALGARY. Construction is progressing on the new \$4,000,000 General Hospital and the east wing as well as the centre portion have been built. This \$3,000,000 section rises six stories above the two basement floors and contains the main wards and service centres. It is expected that this section will be opened for patients early next year. Meanwhile, the footings have been completed for the west wing. Completion of this wing is expected this year and it will contain a children's ward and a psychiatric ward.

* * * *

CALGARY. At the beginning of this month the new \$1,200,000 Red Cross Crippled Children's Hospital was

officially opened. This four-storey, "V" shaped structure has accommodation for 119 patients, with capacity for 20 more in an emergency, and replaces a former 50-bed institution which has been in use for several years. The hospital will serve children from the province of Alberta, the North West Territories, and the Peace River district, whose parents cannot afford prolonged orthopaedic care. An out-patient's clinic is among the features of the hospital.

British Columbia

VANCOUVER. It is expected that a recommendation will be submitted to the federal government for construction of a \$3,500,000 addition to the Shaughnessy Hospital this year. The new structure would be built behind and connected to the main hospital and would replace the present army huts which now provide space for wards and offices. It is expected that the new addition would provide space for 200 beds, a power plant, orthopaedic centre, and various other services.

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The Medical Profession and Community Relations

The medical profession is urged to take steps to meet new responsibilities in community relations, in an article prepared by the Public Relations Committee of the Canadian Medical Association, appearing in the February issue of the C.M.A. Journal. Today, the article states, "The profession's performance must be judged from two aspects: professional conduct and what, for lack of a more specific term, we might call community relations—the complicated interplay of all sociological, political, and economic forces at work in the world today."

One of the most vital needs of modern society is a greater measure of medical care security. The organized medical profession is answering that need, in part, through professionally-sponsored medical care plans. However, the plans as they now exist are not complete and more support from individual doctors, greater patient participation, and less selective coverage are necessary if such plans are to be effective.

Hand-in-hand with the profession's responsibility in community relations is its responsibility in public relations. "The public is the final arbiter of the profession's performance and it can not pass judgment unless it is supplied with information. Worse still, the public may be supplied with misinformation."

Constant vigilance by every doctor and every medical society is required to accomplish good public relations. Finally, Canadian doctors are urged to take the public into their confidence if they wish to receive confidence in return.

Dr. L. O. Bradley Accepts Post on Red Cross Advisory Committee

Dr. Leonard O. Bradley, executive secretary of the Canadian Hospital Council, has been appointed in an advisory capacity as national chairman of the Red Cross Outpost Advisory committee. This committee guides the operations of the 82 Red Cross Outpost Hospitals and Nursing Stations throughout Canada.

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(Concluded from page 30)

costing \$30 to \$40 dollars an extravagance. There are a tremendous number of people from all parts of Canada, many of whom I have met in southern climes, who think nothing of spending hundreds and even thousands of dollars for a trip to the South during the winter months, but who are infuriated when the hospital presents an account for \$200.

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condition of as many Canadians, and often put back on his or her feet a father or a mother with a family to support. Many of them would have been lost, not only to their families but also to their country. We save lives. We relieve suffering. We make people happy.

Helping Hand

One of the main projects of the Canadian Red Cross Juniors is helping crippled or handicapped children. Since 1927, they have assisted more than 36,000 children in Canada and have raised more than \$1,500,000 for this aid. In addition, the Juniors have raised and spent more than a million and a quarter in assistance to children in war-ravaged countries, as part of their program of international friendship and understanding. Administration costs for the Junior organization in Canadian schools are being raised through the Canadian Red Cross \$5,000,000 appeal which is being conducted this month.

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—C. N. Bovee.

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Foot Care Important to Health

When it comes to hard work, the heart outdistances the feet only by a narrow margin, say foot health officials. This is a very good reason why Canadians should know about care of the feet and how to buy shoes for correct fit.

Foot health education should begin at an early age. It is estimated that eight out of ten adults have foot troubles, 85 per cent of which could have been prevented before the feet had completed their growth and development. Widespread ignorance of the fact that it takes 20 years for feet to grow to maturity is the principle reason why so many children have foot defects and deformities by the time they leave public school. Nearly all children are born with perfect feet but by the time they reach their first birthday eight per cent have foot defects. This increases to 22 per cent at the age of two, 41 per cent by the age of five, and at 10 years of age the number has increased to more than 50 per cent.

Few children complain about their feet but a recent study showed that

76 per cent of them wore shoes that were from one-half to three and a half sizes too short. Children's feet are pliable and, because of their soft structure, they will conform to the shape of the shoe without evidence of pain until nerves become irritated and the child's health is affected. There are warning signs of foot troubles and of ill-fitting shoes, including unwillingness to walk, run, or play. It is unnatural for a child to be irritable, to wake at night and cry that knees or legs are aching; these signs can result from excessive fatigue due to foot weaknesses or disturbances to which improper footwear may be a contributing factor.

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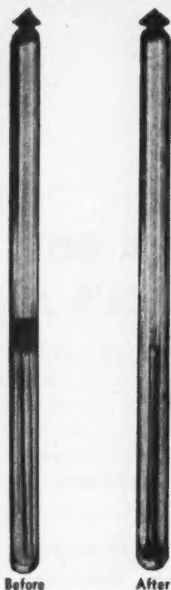
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Federal Grants

(Concluded from page 52)

and infrared lamps, a shortwave diathermy machine, and a Blickman tank for hydrotherapy.

Federal health grants have been allotted to buy 50 incubators for the care of premature infants in Alberta. The incubators will be distributed by the provincial health department to general hospitals which at present do not have them or are inadequately supplied. A few will be kept in reserve for new hospitals. A grant has also been approved for equipment needed by the provincial health department for its immunization and other public health programs. Total cost of the incubators and new equipment will be about \$11,800.

Thirty district nursing stations in various parts of Alberta will obtain additional equipment. The articles estimated at a cost of \$3,600 will include sterilizers, auriscopes, and equipment to protect biological products such as vaccines. At Bowness, a new suburb of Calgary, a part-time public health nursing service is being established and will concentrate on health services for infants and pre-school children. In accordance with Alberta's policy, the local community is meeting 40 per cent of the cost, with the federal government providing the remainder.

Tuberculosis

To improve dental services in Nova Scotia's three provincial sanatoria, federal government has allocated funds to equip dental clinics. Sanatoria which will obtain equipment are the Point Edward Hospital, Westmount; the Roseway Hospital, Shelburne; and the Nova Scotia Sanatorium, Kentville. These clinics will operate during the winter months and will use the staff which is employed during the summer with the province's mobile dental units. Services of the clinics will be available to indigent inmates of the sanatoria and also to children who are wards of the province.

Marry by all means. If you get a good wife you will become very happy; if you get a bad one you will become a philosopher—and that is good for every man.—Socrates.

Through the Palomar telescope it is seen that Pluto is covered permanently with dirty snow. Thus is a sister planet demoted to the status of an industrial suburb.—Winnipeg Tribune.

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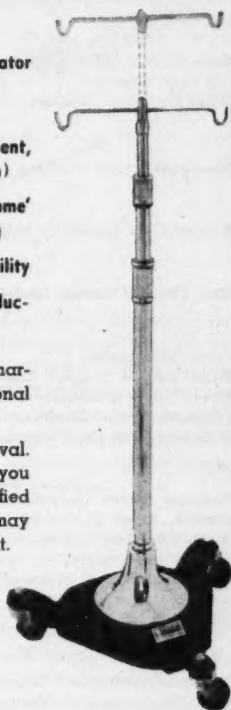
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Index of Advertisers

MARCH, 1951

A		H	
Abbott Laboratories Limited	55	Hartz, J. F. Co. Limited	70
American Cystoscope Makers Inc.	19	Heinz, H. J. Co. of Canada Limited	79
American Sterilizer Company	18	Hobart Manufacturing Co. Limited	74
Arborite Company Limited	74		
Aseptic-Thermo Indicator Company	82, 91	I	
B		Ingram & Bell Limited	5, 18, 19
Bard Parker Company Inc.	71	J	
Bauer & Black Limited	49	Johnson & Johnson Limited	23, 53
Baxter Laboratories of Canada Limited	5	Johns, O. H. Glass Co. Limited	92
Blakeslee, G. S. & Co. Limited	16	L	
British & Colonial Trading Co. Limited	82	Lewis Craft Supplies Limited	80
Brock, Stanley Limited	76	Lily Cups Limited	77
Brunner Mond Canada Sales Limited	67	Livrey Equipment Company	72
C		M	
Canadian Hoffman Machinery Co. Limited	22	Macalaster-Bicknell Company	10
Canadian Hospital	80	N	
Canadian Industries Limited	93	National Cash Register Co. of Canada Limited	89
Canadian Kodak Co. Limited	51	O	
Canadian Laundry Machinery Co. Limited	II Cover	Ohio Chemical Canada Limited	73
Casgrain & Charbonneau Limited	63	P	
Cash, J. & I. Inc.	84	Pacific Mills Limited	4
Castle, Wilnot Company	63	Parke, Davis & Company Limited	11
Civil Service Commission	82, 84	Pfizer, Charles & Company Inc.	8
Clay-Adams Company Inc.	14-15	Physicians' Record Company	78
Coca-Cola Limited	90	Price Jones, John Co. (Canada) Limited	68
Colgate-Palmolive-Peet Co. Limited	91	S	
Corbett-Cowley Limited	III Cover	Seamless Rubber Company	17
Crane Limited	24	Simpson, Robert Co. Limited	91
Crescent Surgical Sales Co. Inc.	12	Smith & Nephew Limited	60
Cutter Laboratories	21	Smith & Underwood	92
D		Starkman Biological Laboratory	88
Denver Chemical Manufacturing Company	75	Sterling Rubber Co., Limited	88
Department of Fisheries	81	Stevens Companies, The	59
Dixie Cup Co. (Canada) Limited	87	W	
Dominion Textile Co. Limited	20	Wells Organizations of Canada	88
Dustbane Products Limited	69	West Disinfecting Co. Limited	7
E		Wilnot Castle Company	63
Eaton, T. Co. Limited	84	Wilkins, Robert C. Co. Limited	68
Edison, Thomas A. of Canada Limited	86	Wood, G. H. & Co. Limited	IV Cover
F		Wooley, Glen S. & Company	92
Ferranti Electric Limited	85	Wyeth, John & Brother (Canada) Limited	61
Fischer Bearings (Canada) Limited	65	X	
Fisher & Burpe Limited	57	X-Ray & Radium Industries Limited	13
Frigidaire Products of Canada Limited	83		
G			
General Electric X-Ray Corporation Limited	9		
Gilbert Surgical Supply Company	93		
General Steel Wares Limited	66		
Gumpert, S. Co. of Canada Limited	3		

(For Subscription Rates See Page 80)

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